# MEDICAL CARE LEGISLATION

# HEARING

BEFORE THE

## SUBCOMMITTEE ON
## HOSPITALS AND HEALTH CARE

OF THE

## COMMITTEE ON VETERANS AFFAIRS
## HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

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APRIL 26, 1989

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# MEDICAL CARE LEGISLATION

**Wednesday, April 26, 1989**

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
*Washington, D. C.*

The subcommittee met at 9:07 a.m. in room 334 of the Cannon House Office Building, the Honorable G. V. (Sonny) Montgomery, chairman of the subcommittee, presiding.

Present: Representatives Montgomery, Rowland of Connecticut, Harris, Kennedy, Patterson, Johnson, Jontz, Payne, Stump, McEwen, Smith, Burton, Stenholm, Hammerschmidt and Rowland of Georgia.

## OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. MONTGOMERY. The purpose of this hearing covers four basic areas. First, we will discuss eligibility for outpatient care at DVA facilities.

Second: resources for care and access to care. We will discuss factors in distributing resources across the country such as in rural and urban care, everyday care and high-tech care.

Third, we will discuss how much it costs to deliver medical care in our VA systems in comparison with what it costs in the private sector. We really don't have a good feel on that.

Fourth will be a discussion on H.R. 1931, a bill regarding certain procreative services for veterans.

We have a number of witnesses and panels, and without objection, my full statement will be put in the record.

[The prepared statement of Chairman Montgomery appears on p. 33.]

Mr. MONTGOMERY. 1Mr. Stump, do you have any comments?

Mr. STUMP. No comments.

Mr. MONTGOMERY. 1Mr. McEwen?

Mr. MCEWEN. I would like my statement entered in the record.

Mr. MONTGOMERY. Without objection, so ordered.

[The prepared statement of Congressman McEwen appears on p. 37.]

Mr. MONTGOMERY. Jim Jontz of Indiana?

Mr. JONTZ. I have a statement I would like to make on H.R. 1780.

Mr. MONTGOMERY. All right.

## OPENING STATEMENT OF HON. JIM JONTZ

Mr. JONTZ. Thank you, Mr. Chairman.

I appreciate the chance to say a few words this morning about the legislation I have introduced, H.R. 1780, to bring order to the way in which the VA provides outpatient medical care by conforming eligibility requirements for outpatient services to those for hospital care.

The Adam Benjamin VA outpatient care facility in Crown Point, Indiana, has turned away veterans seeking care. Regrettably, Crown Point is not the only place that this has happened. The Department of Veterans Affairs says that it cannot afford to treat all Category A veterans seeking outpatient care.

My first reaction to the news from Crown Point was that this was illegal. Category A veterans are always entitled to care at all VA facilities. Unfortunately, this is not the case under Public Law 99-272. The VA has different eligibility requirements for veterans requiring hospital care from the eligibility requirements for outpatient care.

A veteran entitled to care can be turned away when seeking outpatient care, and this is what is happening at Crown Point and many other VA outpatient facilities throughout our country.

H.R. 1780 would bring order to the situation. It does not make sense, in my opinion, to treat a veteran in a VA hospital because he is not entitled to outpatient care. It does not make sense to force a veteran to wait until he is so sick that he must enter a VA hospital when this care could have been provided more quickly and less expensively in a outpatient clinic.

It truly is not fair for a veteran such as a former POW or one earning less than $16,466 for a single veteran or any veteran to go without care because they cannot find a way to get into a VA hospital.

There are, as you might expect, no statistics which show how many veterans are being denied care. But the number of Category A veterans who are being denied outpatient care is surely in the thousands.

For many veterans the VA is the only place to turn for medical care. Over 70 million Americans have either insufficient health insurance or no insurance at all. When we deny outpatient care to Category A veterans, we are in fact in many cases denying them any medical care at all.

Under H.R. 1780, former POWs would receive outpatient care for all medical conditions, as would veterans exposed to radiation and Agent Orange. Mexican and World War I veterans would also receive outpatient care for all conditions. Any veteran earning less than $16,466 or a veteran with one dependent or earning than $19,759 or less would be entitled to outpatient care.

Many would argue that our Government cannot afford to expand veterans medical care. If our objective is only to keep health care costs down, our current eligibility standards for outpatient care should be maintained.

I would argue, however, that it is time for the DVA to bring some rationality to the way that it provides medical care to America's veterans by conforming eligibility for outpatient services at DVA facilities with eligibility standards for hospital care.

Twice, the House of Representatives, under your leadership, Mr. Chairman, has passed legislation which would extend outpatient care eligibility, and twice it has been rejected by the Senate.

The need today is more pressing, and I would urge the subcommittee to approve H.R. 1780 or some comparable legislation.

I do thank you, Mr. Chairman, for the opportunity to present this statement on behalf of H.R. 1780 this morning.

Mr. MONTGOMERY. Thank you very much.

Our first witness this morning is the Honorable Tom Lewis, from the 12th Congressional District of Florida. I might say that we hear from Representative Lewis quite often in that he has a number of veterans in his congressional district and he certainly has shown concern for the veterans and their dependents.

Your full statement will be put in the record, and we are glad to have you before the subcommittee.

## STATEMENT OF HON. TOM LEWIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. LEWIS. Thank you, Mr. Chairman. I appreciate your holding this hearing particularly in the area of concern, nursing homes. The opportunity to be before this committee certainly allows me to voice my strong support for the nursing home portion of the Department of Veterans Affairs of the Schmitt Medical Center in Florida. We all agree that the nursing home is badly needed.

I would like to point out to the committee that I have the VA's own 30-year study right here, which shows that we need in Florida 2,600, almost 2,700 nursing homes. We currently have 810. We need 1,878, Mr. Chairman.

Now, construction of the medical center in West Palm Beach, Florida, has been authorized for a number of years, and in 1986 the site was chosen and preliminary contracts were awarded. And a medical center should have been under construction last year.

The original design of the medical center called for a 625-bed hospital along with a 240-bed nursing home. Since the area's veteran population is rapidly aging and the need for hospital beds is declining, the Veterans' Administration made a decision, which I supported, to cut the hospital beds from 625 to 400 while maintaining their commitment to the nursing home.

The rapid aging of south Florida's residents has reinforced my belief of the importance of a nursing home to serve the many elderly veterans in this area. The south Florida area affected by this medical center has well over 200,000 and close to 250,000 veterans at the present time, with more moving in every day. And at the present time, the only nursing home for South Florida's veterans is a 212-bed facility in Miami. This facility is simply too small and too far away for veterans outside Dade and Monroe counties.

A study by the VA indicates that four or five times the current nursing home beds are needed by Florida's veterans. So, why the VA would not ask for this nursing home, not only did they not ask for it, they did not ask for it, twice.

Last year you may recall that the Administration did not request a nursing home. Your committee realized its importance and placed it back in the budget, and I commend the committee for

doing so. Obviously, the committee shares my belief that this nursing home is indispensable to the elderly veterans of Florida. We cannot ignore the long-term health care needs of those men and women who gave so much of themselves to protect our Nation in the time of need.

There is an undeniable need for the nursing home as an integral part of this medical center. Eliminating it closes the door on the greatest test that this country faces in its commitment to our aging veterans.

In closing, I urge this committee to pass this legislation containing the nursing home for the Palm Beach Medical Center, and I thank this committee for the opportunity to testify. As a veteran myself, I have long been interested in this committee's concerns and have always enjoyed working with this committee to ensure that our veterans are treated fairly.

Mr. Chairman, you are known by the veterans of this country, and particularly those in Florida as a fair man, and so is this committee. I would certainly hope that the committee would see its way clear in order to allow this nursing home.

It would seem to me almost unnecessary that I have to sit before this committee and almost beg. The VA should have faced up to its responsibilities and provided this nursing home for the veterans of this country, particularly those of South Florida, where we have a tremendous immigration of veterans from the North.

Mr. Chairman, I thank you and I thank the committee for listening to my testimony.

[The prepared statement of Congressman Lewis appears on p. 44.]

Mr. MONTGOMERY. Thank you, Tom Lewis.

I might say that you heard the subcommittee proceedings this morning, where one of the three nursing homes that we had to be considered by this administration and the Appropriations Committee, West Palm Beach, so it is in there. And it is really kind of up to you pushing it with this administration, asking for this money, and also with the Appropriations Committee.

Mr. LEWIS. Thank you, Mr. Chairman. You have my commitment and also the veterans.

Mr. MONTGOMERY. Thank you. Does anybody else have any comments?

Mr. STUMP. I would like to thank Tom for his statement, and I look forward to working on the floor with him on this.

Mr. LEWIS. Thank you.

Mr. MONTGOMERY. Thank you very much, Tom.

Mr. LEWIS. Thank you, Mr. Chairman.

Mr. MONTGOMERY. Our first panel—we do have four panels—Dr. Gronvall, Chief Medical Director,Department of Veterans Affairs. Please come forward and introduce those with you.

Dr. ROWLAND OF GEORGIA. Mr. Chairman, I would like to apologize for being late, and to have my vote recorded as yes on the budget resolution and to ask unanimous consent to insert in the record a statement.

Mr. MONTGOMERY. Without objection. And your full statement will be put in the record.

[The prepared statement of Dr. Rowland appears on p. 41.]

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman.

I would like to ask unanimous consent to be recorded on the earlier vote.

Mr. MONTGOMERY. We really didn't have a vote, but we will let the record show that you were here and did vote yes.

I wish I had mentioned to Tom Lewis that the State veterans nursing home, it is a good program and sometimes that is a better way to get you a nursing home in your area is to follow up on the State veterans nursing homes. That is what we have done in my State. It took about 4 years, but it is well worth it. And it is something that can be done, and I would encourage members to look into that situation of State veterans nursing homes.

Dr. Gronvall.

**STATEMENT OF JOHN A. GRONVALL, M.D. CHIEF MEDICAL DIRECTOR, VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY RICHARD J. GREENE, M.D.; ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR FOR RESEARCH AND DEVELOPMENT; ALBERT B. WASHKO, DIRECTOR, NORTHEAST REGION; MARJORIE R. QUANDT, ASSISTANT CHIEF MEDICAL DIRECTOR FOR STRATEGIC PLANNING; RALPH IBSON, DEPUTY ASSISTANT GENERAL COUNSEL**

Dr. GRONVALL. Let me introduce the people at the table with me. To my immediate right is Ms. Marjorie Quandt, who heads our planning office. To her right is Dr. Richard Greene, who is the head of the research programs of the VA. To my immediate left, Mr. Ralph Ibson, from the General Counsel's office; and to his left, Mr. Al Washko, who is our Regional Director for the Northeast Region.

Mr. Chairman, our statement gives detailed comments on the matters before the committee, and I would ask that it be placed in the record.

Mr. MONTGOMERY. Without objection.

Dr. GRONVALL. I will briefly summarize the comments made in our full statement on the four matters before the committee today.

First, in regard to outpatient care eligibility, from my standpoint it is attractive administratively and medically to have a single set of eligibility criteria that could apply to veterans and would then apply across all of the categories of care that we deliver. So, that feature of H.R. 1780 certainly is attractive.

We have only had a short amount of time to analyze the impact of the bill if it were passed, as proposed, and as our statement points out, it would mandate a significant expansion of outpatient medical care to Category A veterans.

And our preliminary estimate—and we think it is a conservative one—is that this would cost something like $1 billion additional to our present medical care system. And on that basis, we cannot support adoption of the legislation, as proposed.

In regard to the proposed legislation regarding procreative services, again this is a complicated matter that has been before the Congress and before the VA on previous occasions.

Once again, we have had a short time to analyze this proposed legislation. The proposed legislation narrows significantly the extent to which we would be able to provide such benefits.

It raises questions about unequal treatment of male versus female veterans that we could expand on in response to questions, but again our most fundamental concern is that the legislation would enmesh the Veterans' Administration in a set of questions about regulating access to procreation and child-bearing that, we think, raise serious legal, ethical, moral, as well as medical issues. And on that basis, we are unable to support the legislation, as proposed.

Mr. MONTGOMERY. Let me interrupt just a minute, Dr. Gronvall, maybe for the subcommittee, so that I will understand better myself.

What you have talked about is the Jontz bill which says that Category A veterans, service-connected veterans and pensioners would be given priority getting into outpatient clinic care as they are given in going into acute-care hospitals. Is that what your bill does?

Dr. GRONVALL. Yes.

Mr. MONTGOMERY. And you are objecting to it for the costs even though you think it would bring good medical service and there is nothing wrong with the concept?

Dr. GRONVALL. Correct.

Mr. MONTGOMERY. Okay. If you would move on to your second point.

Dr. GRONVALL. Two other items are on the agenda for review. First, the issue of VA costs compared to private sector medical costs:

Our statement lists the many studies that have been done in the past to attempt to get an answer to that question. In every instance that we are aware of, such studies have shown that the VA, if it is put on a comparable basis, the VA is either equivalent in cost or lower in cost than is care delivered in the private sector.

Each of the studies that have been done by the VA have been criticized by other outside reviewers such as the Office of Technology Assessment.

We believe that the studies have been done with adequate attention to all of the factors that need to be incorporated in the studies.

So, our own view is that on the record there are a number of studies to demonstrate the cost effectiveness of VA care.

Finally, the committee asked for a number of comments about rural care, and our statement describes the many ways in which we attempt to reach out to veterans who live in rural areas that are distant from VA medical centers or clinics. Only about 3 percent of America's veterans live farther than 100 miles from either a hospital or a clinic.

But we have undertaken some 200 different kinds of outpatient or outreach activities along with some very specifically defined and developed pilot projects to try to reach out to veterans in rural areas.

Our judgment is that our cost allocation process is now neutral and does not penalize small or rural hospitals or clinic activities. And so we believe that we have done a good many things to try to

bring the benefits of VA care to those veterans who live in rural areas.

Mr. Chairman, that concludes my summary of our statement, and we would be pleased to respond to questions from the committee.

[The prepared statement of Dr. Gronvall appears on p. 45.]

Mr. MONTGOMERY. Well, that was brief, and I guess I like that. But I am not sure that I got a lot of answers on the cost comparison. You know, Dr. Gronvall, you've got to come up with something on that.

I have been told from reliable sources that the treatment in the VA hospital could be as much as $100 a day less than it would cost in a private or public hospital. If it is not that much less, then something is wrong with the system. Your medical system is too fat or you're not squeezing it. You've got tremendous volunteers. You have got the university medical support. We don't have any bonds to retire.

You know if you're not doing it, something is wrong, seriously. And that is what I want to talk to the director about out there and ask him.

I hear that you protect the directors, protect sometimes their staffs, since we have to make these cutbacks, and they don't put the people down in the wards where they ought to go and where they ought to be working.

Now, we are cutting back in Government in the medical care, and it's got to show us something out there. We really are working very hard up here to get you additional funds. We are going to have to have some tightening up in your system, and we're going to have some answers that you are doing a better job than they are doing in the private or public sector. If not, something is terribly wrong.

Dr. GRONVALL. I believe we have answered that question to the best of our ability, and the very comprehensive study we did and completed about 2 years ago showed that our costs ranged from either comparable to 20 percent lower on a case-by-case basis than comparable care in the private sector.

So, we believe we have, to the best of our ability, thoroughly studied the question and shown that our costs are below private sector costs. That study suffered from one important factor that physician costs could not be included because the data are not available in the private sector to relate doctor costs to hospital costs.

All of the other evidence that we have shows that physician costs in the VA are less than in the private sector because our physicians are on salary. If that could be added to the study, I believe our cost effectiveness could be shown to be even more significant than the 20 percent figure that I have referred to.

Mr. MONTGOMERY. I hope you can tell that I am not very satisfied with the answers this morning.

Does anybody have any comments?

Bob Stump.

Mr. STUMP. Thank you, Mr. Chairman.

Dr. Gronvall, I represent an area in my State that is 55,000 square miles. That is larger than a great number of States. And

unless one of these veterans lives in one of the metropolitan areas, one of the areas where the VA medical care centers are, they are not going to get any help.

How do you determine what area and what location and what amount of the Department's resources will be allocated?

Dr. GRONVALL. Through our planning system, of course, we at the local level take into account the distribution of veterans across the entire country, and our medical care centers and then our districts propose not only the care at the medical center but outpatient clinics, outreach activities, which are based on attempting to reach out to veterans who don't live close to a medical center.

We also, of course, pay beneficiary travel so that veterans who do live at a distance get reimbursed to a large extent for the costs of coming to a VA medical center or clinic where they come for our care.

Mr. STUMP. Aren't we going to end up with very little rural medical care just because these formulas favor the densely populated areas?

Dr. GRONVALL. The formulas that we use for allocating funds do not favor densely populated areas. Two years ago we made adjustments in our resource allocation model so that hospitals that are in rural or sparsely populated areas are compared to other hospitals in similar areas, and they compete for funds on an equivalent basis.

So, we believe that our funding allocation process does not disadvantage rural or sparsely populated medical care areas.

Mr. STUMP. Mr. Chairman, I do have some questions that I would like to submit for the record, and I know that we go to the floor at 11 o'clock.

Mr. MONTGOMERY. Without objection.

Dr. Rowland?

Dr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman. Good morning, Dr. Gronvall.

Dr. GRONVALL. Good morning.

Dr. ROWLAND OF GEORGIA. I am distressed that you don't support the outpatient care for all Category A veterans. I am astounded at the figure of $1 billion that is mentioned there. When one looks at the number of veterans that would be covered by this who are not covered now: POWs, Agent Orange veterans, World War II, Mexican-American, and the group that makes somewhere between $10,000 and $19,000. It doesn't seem to me like you are talking about that large of a number of veterans.

Let me ask you this question. Could we say it is true that outpatient care is less expensive than inpatient care?

Dr. GRONVALL. Absolutely.

Dr. ROWLAND OF GEORGIA. In that event, it seems to me that there would be a lot of these veterans who would come in that eventually have to get inpatient care, that that could be unnecessary if they were treated on an outpatient basis.

We know the natural inclination of people is not to come in if they think they are not going to get the care, but they are more inclined to come in if they know they are going to get some care. So, they would be inclined to come if they knew that they would

get the outpatient care and not waiting until they got so sick that they had to go into the hospital.

So, it seems to me there would be a significant amount of savings if you treated these patients outpatientwise. Is that a fair statement?

Dr. GRONVALL. Yes, that certainly is true. And we do have current authority to provide outpatient care where it will obviate the need for an inpatient episode of care.

The reason our cost estimate is so large is that there really are a large number of Category A veterans many of whom do not currently come to us for care, and the bill would authorize comprehensive outpatient care to them for all medical conditions.

We would be pleased to submit to the committee the detailed description of how we made that estimate. In my statement I said that we had had a short time. So, it is an estimate made under time pressure. But we believe it is a reasonable estimate of how much additional care we would be delivering on an outpatient basis to the group of all Category A veterans.

Dr. ROWLAND OF GEORGIA. I would like to see that information because that is an astounding figure to me. And I wonder if you have even taken into consideration the amount of savings that you would have if you did not have to put the patients in the hospital. So, I would be very interested to see that.

Dr. GRONVALL. We will submit that.

Dr. ROWLAND OF GEORGIA. Thank you.

(See p. 59.)

Dr. ROWLAND OF GEORGIA. I think one of the most important services that the Department of Veterans Affairs provides is being able to provide care in the rural areas to veterans.

And as you know, recently the hospital in the district that I represent—in fact, my hometown—there was a proposal to remove the surgical unit out of that hospital there.

As I understand it, bearing in mind that this surgical unit was doing a lot of elective-type surgery—hernias, hemorrhoids, those types of things—and that they were not doing enough surgery to justify keeping that facility there, but I also understand that there is a waiting list for elective surgery at the VA hospital in Atlanta that they were talking about moving the patients who had been getting care from Dublin to Atlanta. It's no further from Dublin to Atlanta than from Atlanta to Dublin.

So, my question to you is why were these patients who are on a waiting list in Atlanta for elective procedures not be allowed to go to Dublin to get those procedures done?

Dr. GRONVALL. I would have to make a specific review of the issue of Dublin and Atlanta. I don't have information at my fingertips on that.

Dr. ROWLAND OF GEORGIA. I know you don't.

Dr. GRONVALL. As a generalization, in a number of instances where we have had surgical services being provided in our smaller medical centers, we have found that as the amount of surgery being done progressively declines, it becomes increasingly difficult to retain fully and highly qualified staff, both anesthesiologists and surgeons. And so in a number of places in the country due to quality-of-care considerations we have proposed closing acute surgery

and relocating the surgical program to a larger hospital to ensure that the quality of care would be better.

That was the basis, of course, of the special review we did of open-heart surgery. As a result of that review, we made a decision to discontinue open-heart surgery in four of our medical centers.

I would like to look into the Dublin and Atlanta question, though, and get back to you.

Dr. ROWLAND OF GEORGIA. I would like for you to specifically address that and I would like for you to address that in general.

I would like to know if there are other hospitals around the country in rural areas that could be fulfilling a need but yet they have these tertiary hospitals wherein that type of surgery is being withheld and not sent to the rural areas to be done.

So, if you would supply that information, I would be very grateful.

Dr. GRONVALL. I would be pleased to.

(Subsequently, the Department of Veterans Affairs furnished the following information:)

There is no rule or precedent which prevents a veteran from seeking medical or surgical care in any VA medical center. Therefore, any veteran from the Atlanta area who wishes to be treated at the VAMC Dublin may seek care at that facility. The surgical service staffing at the VAMC Dublin involves one genitourinary specialist and two general surgeons. Therefore, the type of surgical care is limited. I am informed by the Chief of Staff at Atlanta that there is a waiting list for elective hernia repair and other surgical procedures which normally we would classify as less complex procedures. I must emphasize that many veterans with relatively uncomplicated types of abnormalities requiring surgical treatment also are suffering from one or more organ system diseases or abnormalities. Therefore, in the older, sicker patients, relatively simple surgical procedures are frequently more complex and in some instances, life threatening procedures. For this reason, treatment of these high risk patients in a tertiary care medical center is essential. These patients require support from many disciplines and it is the tertiary care facility which has the multiple specialty and subspecialty clinicians available for that support care. I have been informed that rather than referring patients to Dublin, patients requiring more urgent types of less complex surgery, therefore, are being referred to the VAMC Tuskegee where additional support services are available. The Atlanta VAMC will, however, reassess elective surgical cases to determine if referral to Dublin is indicated.

Members of my staff have communicated with six VA medical centers located in relatively rural areas and not more distant than approximately 200 miles from a tertiary care facility. None of these facilities had received any veteran patients as referrals from the tertiary care facilities. Many veterans requiring surgery for less complicated problems and who were in relatively good health with no other chronic ailment present were being operated in the tertiary facilities through the Ambulatory Surgery Program. Similarly, those patients apparently requiring less complicated surgical procedures, but whose general physical condition placed them at higher operative risk were being cared for at the tertiary care facilities where more support care was available.

Dr. ROWLAND OF GEORGIA. I have some more, but let me pass now. My time is up. And maybe before we leave, you could come back.

Mr. MONTGOMERY. Okay.

Dan Burton?

Mr. BURTON. Thank you, Mr. Chairman.

I just want to follow up on Dr. Rowland's question. It seems to me that if your cost estimate is accurate, $0.5 billion to $1.0 billion, you are assuming that there is going to be many, many more people coming in for outpatient care than is currently the case, and that those people would be coming in for outpatient care even

though they would not be coming in for inpatient care. Is that your assumption?

Dr. GRONVALL. The assumption is based on our present experience of veterans who come to us seeking care. Generally when a veteran comes, he or she is seeking medical care, they don't come saying I need to be in a hospital or I need outpatient care.

Based on our current experience, a good many veterans that come to us seeking care do not need hospital care, they need outpatient care. However, they fall into an eligibility category where we are not obligated to provide the care presently because of the budget constraints, then we refer them elsewhere.

So, it was on that basis and also assuming that we would provide comprehensive outpatient treatment for all conditions that we projected our estimated cost to all of those veterans who would come to us for care.

Mr. BURTON. Do you have the numbers of veterans that are referred to other facilities or institutions because they do not qualify?

Dr. GRONVALL. Yes, we surely do.

Mr. BURTON. And would qualify under this?

Dr. GRONVALL. Yes. We keep detailed records of all veterans who apply for care and then what happens to them, how many we treat, how many we refer elsewhere. We have detailed information on all applicants to the VA.

Mr. BURTON. I assume that information would be included in the information you are going to send to Dr. Rowland?

Dr. GRONVALL. Yes.

Mr. BURTON. I would like to see that, too.

Dr. GRONVALL. I will be pleased to submit it.

(Subsequently, the Department of Veterans Affairs furnished the following information:)

During the first 6 months of fiscal year 1989, the Department of Veterans Affairs received 1,630,053 applications for medical care. Of this total, 9,438 applicants were referred to other facilities or istitutions.

Mr. BURTON. Thank you, Mr. Chairman.

Mr. MONTGOMERY. Do any members have any comments?

Mr. STENHOLM. Thank you, Mr. Chairman.

Ms. Quandt, could you describe in detail the two rural health pilot programs, their cost thus far, and maybe a current update on what is happening in those two programs?

Ms. QUANDT. Yes. In response to interest that has come about from Congress, we have started two rural health care projects as health systems research and development projects. One is in Farmington, New Mexico; the other is in Redding, California. Both projects have been in operation a little over a year. They were established on the basis that there was no VA presence within 100 miles or two hours of travel time; and that they were in a health manpower shortage area.

After selecting those facilities which are more than 200 miles from their home facility, Farmington was established on a sharing agreement program with Presbyterian Medical Services. We share their facility. We have on contract one of their physicians, a half-time physician assistant; and we supply seven staff from the Albuquerque Hospital.

They are accomplishing approximately 11,000 visits a year at a cost of $64 a visit.

The Redding clinic is a different model. It is fully staffed by VA personnel. It has 17 full-time personnel. It offers a slightly broader program than that of Farmington. It has a program for 15,000 visits which are estimated to cost $156 per visit.

Both programs are being evaluated for quality of care, patient satisfaction, and cost effectiveness by our health services research and development unit at Palo Alto, California.

Mr. STENHOLM. When might we expect some of the results of some of the evaluations, the comparable cost—for example, you gave the cost per visit—and how this compares with the cost had these pilot projects not been there?

Ms. QUANDT. The official evaluation report will come in April of 1990. We could make some assumptions for you based on other existing satellite clinics and outreach clinics currently.

We have, by the way, 136 outreach clinics, which means they are well over 100 miles from the home facility and they have all been established in the last 2 fiscal years.

Mr. STENHOLM. Do you have any preliminary information that might indicate that it is efficient to have outreach clinics?

Ms. QUANDT. Those clinics operate essentially with one or two staff. It is what I call a roving clinic. It may be a flying-in team, it may be a traveling team. We can provide cost data. We have done no quality-of-care evaluations comparing those to either satellite clinics or clinics within our VA facilities.

Mr. STENHOLM. Mr. Chairman, I think it would be extremely helpful if we have a preliminary analysis of these within the next several months because of the effort of providing overall rural health care which we now have an Administration task force set up to look at as well as considerable effort within the Congress to look at it.

So, I think that this information that you are in the process of pulling together would be extremely helpful to us as we look at the overall subject of rural health care.

I think it would be very helpful if we have a preliminary report, to the best of your ability, as soon as you can get it.

Mr. MONTGOMERY. I certainly agree.

And I would like to instruct staff that when we do get this report, that we get it to members, informally that we do meet and talk it over. A lot of times these reports come in and we never see them. There is so much going on, it is really hard to follow up.

So, I would like to make that request and instruction.

(See p. 70.)

Mr. MONTGOMERY. Anyone else have any comments?

Claude Harris of Alabama.

Mr. HARRIS. Just a short comment.

I just want to associate myself with the remarks of Mr. Stenholm and the chairman because our State, if I am not badly mistaken, leads the Nation in the closing of the rural hospitals. So, this is something that is very near and dear to me, and I think it is something that we can be looking at also. So, I look forward to seeing the reports so that we can examine it further.

Mr. MONTGOMERY. Thank you.

The gentleman from Connecticut?

Mr. Rowland of Connecticut. Thank you, Mr. Chairman.

Just a few quick questions, if I may.

Dr. Gronvall, with regard to cost comparison, I understand the department has two studies that have been done over the years, one in 1977 and the second one done in 1986.

We are at the point now where we need to say once and for all that the DVA health care is less expensive. Can we say that without question at this point?

Dr. GRONVALL. I believe that the answer is yes. What happened, of course, is since the VA did those studies, people outside the DVA criticized them and accused us of having a self-interest in showing that we were of lower cost.

I believe the studies are conclusive and objective and fair. But they have been criticized. So, in fairness, I want to refer to that.

Mr. Rowland of Connecticut. Assuming objective and fair, how has this information been used to gather support for continued funding or adequate funding for health care for the DVA?

Dr. GRONVALL. When we did the most recent study, it was in response to a specific White House working group request. So, this study was prepared, was submitted to the White House. It was discussed there and by other Federal health agencies. It was made available to OMB.

We have referred to it regularly when we defend our budget in OMB hearings, and the study has been provided to the Congress. So, we have tried to do everything we could to call attention to the fact that VA is cost effective.

For example, periodically the question comes up about veterans who are eligible to come to the VA but also eligible to be treated through the Medicare program. Whenever we have had a chance to comment on that, my perspective on that is that the country, the taxpayers, will get a better break by having the veteran treated in the VA hospital rather than through the Medicare program.

Mr. Rowland of Connecticut. If I may, I hesitate to go back to a question that at least two of my colleagues have asked, and that is with regard to H.R. 1780 and the $1 billion price tag, and I appreciate the fact that you will get us specific information.

I guess what I want to do is get over the feeling that I have that—and I am not sure if, A, the savings have been built in, if you project any savings with outpatient care. You keep using the term "comprehensive," perhaps Dr. Rowland would know better than I.

But when you refer to comprehensive, what additional services do you see that are going to be so costly, and do you also see the size of the patient group expanding so dramatically that it is going to increase those costs and have the savings built in?

And the last question would be is it $1 billion cost the first year and less thereafter?

Dr. GRONVALL. The last part of that question, our estimate is based on a set of assumptions, which we will supply, which we believe will show that expanding that entitlement for total outpatient care for any medical condition to all Category A veterans would result in a major expansion of the amount of medical care that we are delivering.

The word "comprehensive" only means that any Category A veteran could come to the VA for any kind of medical care.

Mr. ROWLAND OF CONNECTICUT. For example, maybe that will help me. Right now, what do they have, and under this provision of comprehensive care what would they get in addition?

Dr. GRONVALL. If the veteran has some sort of heart disease and is not service-connected for heart disease or does not meet the current mandatory eligibility for outpatient care, if that veteran was Category A on the basis of the income stream, that veteran could come to us for complete continuing medical care of his or her heart disease problem.

At the present time, if that veteran came to us, we would do a medical evaluation, we would say you have a heart disease problem that needs continuing outpatient medical care but you are not mandated to receive that care in the VA. And so our social workers would help try to refer the veteran to private medical care.

Dr. ROWLAND OF GEORGIA. Knowing full well it would be more expensive somewhere else?

Dr. GRONVALL. Yes, but we operate within a fixed appropriation, of course, and so it is on that basis that we would make the judgment about the additional amount of medical care that we would be obligated to provide.

As I have already said, I have no medical or administrative reason for saying that the bill does not provide an effective way for the country to decide to deliver the care. Our comment on the bill comes from a tight budget constraint which has been set around the domestic budget which leads us to assume that we would not get funded for that kind of an expansion.

Dr. ROWLAND OF GEORGIA. Thank you very much. That helps a little.

Mr. MONTGOMERY. Thank you. We brought Mr. Washko in from the northeastern region. We are not going to let him come all the way down here without getting involved.

I have been concerned. I have had some personal complaints come to me that the directors of the different hospitals, including the regional offices that overlook the hospitals, have kind of got the good-old-boy attitude, that the directors see that their staffs around them are taken care of and when we have cutbacks from OMB, then it gets done to the wards. And it is human nature. I am not sure we wouldn't do it up here either. But it is human nature that the director kind of takes care of himself and the people around him.

Are you having that problem? Was Dr. Gronvall talking to you about this situation and what is happening?

Mr. WASHKO. As we have had to adjust to these budget stringencies, our hospitals have been forced to make reductions across the board. Not only have they made reductions in some of their administrative staffs—and I know of many, many instances where that has been the case—we have also been forced to make cuts in clinical programs, all of which deeply grieve us, really, because we are not providing the quantity of care that we would like to provide nor are we providing, in many cases, the quality of care supported by the appropriate staff, both clinical and administrative, that we would like to provide.

Now, sometimes people confuse administrative people as not being effective in the medical care process. You have to have a certain amount of clerks and so forth so that clinical people don't end up running lab tests back and forth to the lab or they don't end up fetching sheets for themselves. So, we have tried to maintain some balance in this.

Mr. MONTGOMERY. I hope it is not taking place, and you are assuring the committee this morning that in your region that the director and his personal staff are taking just as much a lick as they are down in the wards, in the surgical part, the pharmaceutical?

Mr. WASHKO. Absolutely. As a matter of fact, I am in the process of putting some overhead data, overhead costs to medical care, so that I can compare my hospitals in the northeast with each other in terms of how much overhead they are expending, you know, over and above the medical care costs. That is something that I am specifically looking at.

Mr. MONTGOMERY. That's good. I am glad to hear that.

Dan, let me get Mr. Kennedy. Would that be all right?

Mr. BURTON. Sure. Go ahead.

Mr. KENNEDY. I appreciate it. I have a markup on another committee going on at the same time. I appreciate your help.

Mr. Chairman, the bill I filed will provide infertility services and adoption services to veterans with service-connected disabilities that impair their ability to have a child.

There are times when a wheelchair simply isn't enough to provide the kind of care that the VA and our country has in terms of technology. We have the funds, and what we need is the VA's cooperation. We are not talking about in vitro fertilization or surrogate mothers. We are talking about basic technology that currently exists.

I am proud to say that Dr. Rowland as well as Mr. Bilirakis have both supported the legislation.

Essentially, there are some 15,000 individuals in the VA at the moment that have the potential of being treated through these kinds of services. Only a small percentage of those individuals would ever realistically take part in the service. And what we have is a situation where we have the technology, we have the funds, and what we need is the basic desire of the VA to serve the PVA and other individuals that have these problems and difficulties.

There is work going on right now in Mr. Washko's area in my State where the VA has in fact done an enormous amount of research work and broken through tremendous barriers of being able to provide services to those individuals that are paralyzed and want to have children.

What I wonder is whether or not, in the written testimony that you provided us, Dr. Gronvall, I understand that the VA does not classify infertility as a disability and that is the basic reason why you feel that the VA does not have the authority to provide infertility services. Is that correct?

Dr. GRONVALL. That has been a legal determination that our general authority to provide medical care does not extend to providing support, treatment, devices to deal with the effects of a medical condition.

Mr. Ibson, from the General Counsel's office, really would need to speak to that to be more precise than I can be about the eligibility issue.

Mr. KENNEDY. Fine. Go ahead.

Mr. IBSON. There is a good deal of controversy on just what is the nature of the disability. The traditional VA view has been that of viewing disability in the narrow sense as the physical impairment. And in that context, viewing our mission as providing treatment for but not to overcome that disability, we have conceded that medical determination could be made that infertility itself could be deemed to be a disability. We have a regulation which would have to be amended to change that, and we would certainly have to have the support of the medical community to reach that judgment.

Mr. KENNEDY. Well, I guess I am kind of amazed to hear that we can't at the moment consider that to be a disability because don't we in fact make disability payments to paralyzed veterans for the fact that they cannot have children?

Mr. IBSON. We do so based on provisions of a different part of the code.

Mr. KENNEDY. Different what?

Mr. IBSON. A different part of Title 38.

Mr. KENNEDY. Doesn't Title 38 say that loss of use of creative organs are a condition that warrants disability compensation?

Mr. IBSON. Yes.

Mr. KENNEDY. Well, what can be more of a creative organ?

Mr. IBSON. I am distinguishing between provision of disability benefits, which is based on different legislation than is our authority to provide medical services.

Mr. KENNEDY. Are you telling me, sir, in all seriousness that if Title 38 has specific language referring to creative organs and if you are currently making disability payments to individuals that have been paralyzed and are unable to have children, and all our bill does is allow you to make payments to provide for artificial insemination or other drugs in other types of program and treatment—not surrogate mothers, not in vitro fertilization, no test tube babies—that you can't find a way to interpret "creative organs" or to recognize that you are already making those payments to individually impaired vets, that this isn't just a logical extension of that?

Mr. IBSON. We are obliged to administer the laws that have been enacted. I have not seen a basis to reach that creative determination. Should the committee enact this law and do it over the concerns that have been expressed by the Administration, I am quite certain that the Department of Veterans Affairs will provide that benefit.

Mr. KENNEDY. Thank you very much. I hope the committee will see its way free to pass this legislation and you will be able to provide the services to the committee.

Thank you very much, Mr. Chairman.

Thank you, Doctor.

Mr. MONTGOMERY. We plan on having a vote on the legislation in the next couple of weeks.

Mr. KENNEDY. Great. Thank you.

Mr. MONTGOMERY. Dan Burton?

Mr. BURTON. You have one more cosponsor.

Mr. KENNEDY. I would appreciate it, Dan.

Mr. BURTON. I have one question, Mr. Chairman.

That is, have you considered for the outpatient care problem, and also the rural health care problem, maybe a pilot program to see if your cost figures are accurate? And is that something that you might look at in the future?

Dr. GRONVALL. The pilot projects that Ms. Quandt described include a specific evaluation of our cost figures to see whether it is a cost-effective way of delivering care. We are specifically addressing that question.

Mr. BURTON. You have then some trial testing out in the field to see what the cost figures would be for both outpatient and rural health care?

Dr. GRONVALL. Yes.

Mr. BURTON. And that is what you base your figure of $1 billion on?

Dr. GRONVALL. No. The cost estimate that we supplied related to that new piece of legislation. That was based on the number of veterans who currently come to us or may come to us who fall in Category A priority for care and for whom we would then be responsible for providing comprehensive outpatient care wherever they live. So, that was done on a different basis.

Mr. BURTON. I would say, Mr. Chairman, that I assume that they have done this testing out in the field to find out if it is feasible to do this. But if they haven't, and if it hasn't been thorough enough, I would suggest that that might be one course of action this committee might suggest to them.

Dr. GRONVALL. I must say the legislation, H.R. 1780, has just been introduced within the past couple of weeks. We have not conducted any pilot project to assess the cost of delivering medical care based on that specific proposed change in legislation.

Mr. BURTON. You just said a while ago it was going to cost $1 billion, as an estimate.

Dr. GRONVALL. That is based on the information we have available about the number of veterans who currently come or would come to us for care.

Mr. BURTON. You don't have any pilot program that would give you any hard figures?

Dr. GRONVALL. The legislation was proposed, I believe, two weeks ago. We of course have not done a field pilot project.

Mr. BURTON. That is one of the things that might be worthwhile looking into, Mr. Chairman.

Thank you.

Mr. MONTGOMERY. I agree.

Dr. Rowland?

Dr. ROWLAND OF GEORGIA. I want to go back to the point that you made initially, and I want to address this to Mr. Washko, regarding the cost of care in the Veterans' Administration.

As I understand, you have got a research group in your region now that is looking at the cost of care in the Veterans' Administration and you are comparing that cost of care to what is taking place in the private sector.

Can you tell me about where you are with that?

Mr. WASHKO. I have had a management science group for the past couple of years that has been helping me make cost evaluations and cost studies for medical centers in the Northeast Region.

Essentially, I am responsible for about $1.5 billion in medical care expenditures, and I have always felt that it is incumbent upon me to have a variety of statistical indicators and to be able to compare my costs not only to other VA hospitals but to other medical centers, non-VA medical centers as well.

We are in the beginning phases of gathering some private sector data from hospitals in the Northeast that I could compare some of my medical centers' costs in various areas. This potentially would be expandable to the country, and we have had some conversations in the central office about that. But it is something that we have been interested in for some time.

Dr. ROWLAND OF GEORGIA. I want to commend you on that. I think it is so important for us to understand the difference in costs between VA hospitals and also the VA hospitals and the public and the private sector.

Dr. Gronvall, how do you feel about what Mr. Washko is doing with reference to this research?

Dr. GRONVALL. I believe that each of our regional directors has a responsibility to be doing various kinds of assessments about how care is administered and delivered in their parts of the country and how it compares to the care at affiliates, et cetera.

I think the effort he has under way would not be and would not produce a national answer in an objective fashion to the question that the Chairman has posed to me: What is the overall comparison of VA cost effectiveness to private sector?

Dr. ROWLAND OF GEORGIA. May I interrupt and say that he stated that is could be expanded to a national level. Would you support that?

Dr. GRONVALL. The effort that he has under way could be expanded to a national level effort. I have concern about the worthwhileness of the VA basically repeating a study that we did 2 years ago.

Dr. ROWLAND OF GEORGIA. That study did not give us the information that we wanted. I believe you said it did not give us the information we wanted. We could not compare physician fees. I believe it was like comparing apples and oranges to some extent. Was that not true?

Dr. GRONVALL. Yes. But I believe that same limitation will still occur in the effort that Mr. Washko's staff has under way.

Dr. ROWLAND OF GEORGIA. Then he is wasting his time in doing this, I guess, if we are not going to get any information out of it that we didn't get from the study——

Dr. GRONVALL. I believe that if all of those kinds of detailed cost comparisons were to be really reduced to an objective study, let's say, that would withstand scrutiny by the Office of Technology Assessment, General Accounting Office, that is a very major undertaking that probably should be done by some kind of an objective group through collaboration with both the VA, Medicare, American Hospital Association, American Medical Association, to try to marshall the kind of information that would be necessary to ad-

dress those kinds of questions. It is a complex undertaking of major proportions.

Dr. ROWLAND OF GEORGIA. Mr. Washko, I do not want to put you in an adversary situation with Dr. Gronvall there, but is that your opinion too?

Mr. WASHKO. We are beginning to grapple with a number of these issues. We are in the process of beginning a macro comparison of costs between some of our hospitals and some of our affiliates and other private sector hospitals in the Northeast. These would be costs for admission, equipment inventories per admission, that kind of thing.

We are working with one of the better economists in the country, Dr. Robert Newhouse, who has just left RAND and has been recruited to the Harvard Medical School Department of Health Services Research.

We are in the process of actually hiring a person that we would share between Dr. Newhouse and our group. A second phase would begin to grapple with some of these complexities that Dr. Gronvall was raising. And we are considering working with the Dartmouth Medical School. Dr. Jack Winberg has a tremendous amount of data that he has looked at for some time. Dick Greene and I have had some conversations about collaborating in some of these complexities because there are a lot of costs, the cost of capital, that need to be backed out, the physician costs. We provide dental services that are not provided in the private sector. A number of these areas.

Dr. ROWLAND OF GEORGIA. Let me ask you this: Would legislation from this committee be helpful to you if we passed legislation? Can you proceed on your own initiative with doing this? Apparently, from what you say, you have got some economies to field. Some very valuable information can be obtained from this study.

Mr. WASHKO. Dr. Gronvall indicates he expects all regional directors to manage their own costs in their own areas. And we are all involved in various statistical analyses, cost comparisons. I would have to rely on Dr. Gronvall's direction, of course, about expanding it to a national study.

Dr. ROWLAND OF GEORGIA. Dr. Gronvall, are you inclined to do this, to expand it to the national level, so that we can get some general answers? I am not talking about detailed answers in every aspect of the providing of care, but some general answers about cost comparisons.

Dr. GRONVALL. I am not inclined to do it at our own initiative, for the reason that a prior effort done that way fundamentally met with criticism from outside the VA on the basis that we had a self-interest in proving that we were cost effective.

Dr. ROWLAND OF GEORGIA. What's wrong with that?

Dr. GRONVALL. Well, then the study report is not viewed as valid by people outside the VA.

Dr. ROWLAND OF GEORGIA. Mr. Chairman, my time is up. I could pursue this another two hours. But I will pass.

Mr. MONTGOMERY. Which one of you wants to preside after we get back? You've got it then, Mr. Jontz.

Before we recess, can you, just in your own mind, in the northeast region, can you have a figure of what we might be able to

treat patients at a more reasonable rate? Do you have a figure in your mind that you are thinking about?

Mr. WASHKO. I am not quite following your question, Mr. Chairman.

Mr. MONTGOMERY. I have been using $100 a day cheaper. Have you got, that as you work on this go-around, do you have any figure at all in mind? I am just trying to get——

Mr. WASHKO. Not as yet. We don't expect our macroeconomic analysis to be finished until October 1 of this year. And then we may be able to make some better guesses, but that would only be sort of a first phase in being able to answer that question.

Dr. GRONVALL. If I could add a comment. The study we did included detailed information that we got from one of the major non-VA hospitals in New England, and the cost comparison was striking. The VA was some 20 percent cheaper on a case-by-case basis than a major New England hospital.

Mr. MONTGOMERY. What would that be? I put down $300 a day. That would be—20 percent—would be $60. Is the care that much higher in New England per room per day?

Ms. QUANDT. That study was done on the basis of diagnosis-related groups. So, we were able to tell the difference between their charges versus our costs. And for example, for some of those DRGs we were 67 percent less than that private teaching hospital.

However, if you looked at some of the cardiology DRGs, we were at exactly the same price. It depends upon what specific medical condition you are measuring. But in that one instance, we had clear evidence that we were less costly than the private sector.

Mr. MONTGOMERY. How much do you say?

Ms. QUANDT. In one instance of one DRG, we were 67 percent less, providing the same care.

Mr. MONTGOMERY. Mr. Jontz, after the recess, Dr. Falcon has a statement supporting Category A.

The subcommittee now stands in recess.

[Recess.]

Mr. JONTZ (presiding). The subcommittee will come to order.

I want to call forward Dr. Spencer Falcon.

We want to welcome you, Dr. Falcon, and we appreciate your patience in waiting. We ask you to proceed when you are ready.

## STATEMENT OF SPENCER FALCON, M.D., MEMBER, AMERICAN PSYCHIATRIC ASSOCIATION

Dr. FALCON. Thank you very much, Mr. Chairman.

I would like to express the appreciation of the American Psychiatric Association for the opportunity of coming here and presenting our views. I have submitted a written statement. I would like to summarize some of the key points.

I am president of NAVACOP, the National Association of VA Chiefs of Psychiatry. As president, I think that we have some very specific concerns regarding particular aspects of rural health care. Actually an aspect of rural health care that was not touched upon this morning is that of the large rural neuropsychiatric hospitals.

The neuropsychiatric hospitals are those in which at least 50 percent of the total hospital beds are given over to psychiatric or sub-

stance abuse treatment. Of the 24 large VA neuropsychiatric hospitals across the country, 21 are located in rural settings. Therefore, they experience all of the problems associated with rural health care, but in addition they have the added difficulty of not being able to attract and acquire the necessary particular physicians for that kind of facility.

For the most part, these rural facilities are isolated from potential medical school affiliates and cannot gain the necessary kinds of support and assistance for education, recruitment and retention, or quality assurance.

These hospitals treat patients with the most severe psychiatric illnesses, including schizophrenic disorders and psychotic disorders and serious organic mental disorders. About half of the patients who are admitted into the chronic-care units of these hospitals, which are called intermediate medicine units, have very significant psychiatric illnesses and 92 percent of the patients that were discharged from these hospitals in recent years have been considered Category A or service-connected.

We are dealing with a very difficult-to-manage population of individuals with long-term chronic psychiatric illness. These problems are compounded by the fact that these rural facilities have become, in many respects, the final referral site for these difficult-to-manage patients from urban or other rural areas that do not have psychiatric care facilities.

These large neuropsychiatric hospitals house many of our alcohol and substance abuse treatment beds in the system. As we witness the terrible toll resulting from active disorder conditions, for example the development of cirrhosis of the liver in alcoholics who are untreated or the development of AIDS in individuals who use IV substances and who are untreated, we are concerned that particular support needs to be given to these types of mental health care delivery units.

If psychiatric facilities can provide effective or early treatment of these conditions, substantial morbidity and mortality at a later point in the veteran's life may be prevented, and there are grave concerns now from NAVACOP as to the eventual fate of these facilities.

We also feel that the Department of Veterans Affairs should certainly continue to forge forward to assume more of a leadership role in substance abuse and alcohol treatment, both in research and in education, which is so important at this point in time since people are recognizing the national crisis associated with substance abuse.

Since the implementation of the resource allocation methodology and the increasing budget constraints associated with life these days, there has been a substantial change in how care is delivered at these large neuropsych facilities. Increasing support is going to outpatient and alternative care delivery while at the same time the core funding, the basic funding that keeps critical medical units effective in these hospitals has, in effect, decreased.

What has happened is that with shorter lengths of stays, more patients have been admitted and discharged, but there has been no real change in the actual staffing that exists on the units. So, the patients have become more acute and a revolving door has evolved

where patients are readmitted, sometimes after a fairly brief hospitalization, for another hospitalization.

One of the final impacts of this is how this change in delivery has affected our ability to recruit psychiatrists. Psychiatrists no longer wish to come to these institutions to practice, and therefore we have seen a substantial decrease in our ability to maintain an adequate number of staff in order to provide the quality of care that is essential for the veteran patients.

Thank you.

[The prepared statment of Dr. Falcon appears on p. 77.]

Mr. JONTZ. I do appreciate your statement, Dr. Falcon. And as a Representative of the district that includes one of the hospitals you are speaking of, I think your comments are pertinent.

Did you wish to make any comment with regard to the H.R. 1780, the legislation pertaining to outpatient services, or did you not?

Dr. FALCON. I would. And this is a comment that is made entirely from the standpoint of medical care delivery and not at all saying that the costs of this may be exorbitant or however this may be resolved.

We have found that for certain kinds of medical care delivery, particularly the delivery of care to people with alcoholism and substance abuse, if the care is to be effective, it is most effective if it is given earlier on in the treatment plan. If one waits until a patient has become indigent, has become divorced, or has lost his or her job, before being able to intervene with the care, then the probability of a positive outcome is substantially less.

Therefore, we would support any type of legislation or concern that would attempt to provide earlier intervention with these types of patients.

Mr. JONTZ. Thank you.

I might ask a second question. I understand that you are a member of an advisory committee on post-traumatic stress disorder.

Dr. FALCON. Yes, I am.

Mr. JONTZ. Perhaps you could summarize for me what the work of the committee has been.

Last year, my colleagues Sam Gejdenson and Mr. Levin of this committee and myself introduced legislation to mandate establishment of PTSD programs in VA hospitals. And I don't know that there are plans to reintroduce the bill that was introduced last year, but a number of us are interested in seeing that more is done to address PTSD problems. And again, at the Indiana VA facility we have had a successful program. Regrettably it has been only able to address the most severe problems and doesn't become anywhere near close to dealing with all of the instance of PTSD that we have in veterans within our service area.

But I am interested in what the advisory committee has been doing, and maybe you could describe that for us.

Dr. FALCON. I will try.

Briefly, the "special committee" is what it is called: Chief Medical Directors Special Committee on Post-Traumatic Stress Disorder. It has been in existence for approximately 5 years, and I was one of the original members.

We have submitted annual reports that have been reviewed and then submitted to Congress that have tried to look at the educational, treatment, and research patterns for post-traumatic stress disorder around the country.

We have made a number of recommendations and a number of these recommendations have been acted upon by the Veterans' Administration.

This year, actually over the past couple of months, 30 treatment sites were established for PTSD treatment teams around the country where it was decided that a special group of almost consultant level would work in a particular hospital or a particular medical district to provide that resource to an area.

The special committee has been very active in reviewing what happens on PTSD treatment units, which are specialized units within general hospitals and frequently within the type of neuropsychiatric hospital that I am talking about, and has also been active in reviewing the access-to-care issues for PTSD. And that certainly brings up the issue of outpatient Category A problems.

We have also been involved with reviewing the vet center functions around the country and have created a large body of information regarding utilization by looking at the geographic distribution of services around the country, who uses it where and where does it appear to be lacking, particularly as this utilization matches with what we believe to be concentrations or pockets of areas where there are a large number of veterans, combat veterans who may in fact have post-traumatic stress disorder.

So, it has been an active and interesting committee, and we would hope that it would continue to be.

Mr. JONTZ. I appreciate that, and I look forward to learning more about the committee's work.

One of the criticisms that I have heard from veterans about our PTSD program in Marion—and I assume it is typical of others—is that there is little follow-up. Once the veteran leaves the facility, there is very little that is done on an outpatient basis. And I presume that this relates to the revolving-door problem because I know that many patients return to Marion several times, and if we could do a better job of providing follow-up care in an outpatient setting.

Let me just ask for your impression of the job that is done now in follow-up to PTSD programs.

Dr. FALCON. This varies around the country, as one would think. But one of the problems I believe we have had, in the VA, as far as mental health delivery is our frequent inability to function with the continuing care model. So that in order to assure outpatient follow-up following inpatient treatment, people may be referred from 100 or 200 miles away to your facility.

Mr. JONTZ. Absolutely.

Dr. FALCON. And it becomes difficult to establish some way to have continuity of care.

There has been, I believe, substantial work done between mental health behavioral science and readjustment counseling service to try to coordinate the vet centers with the hospital in providing this continuity of care. This is usually on a district basis, to try within a medical district to develop complementary patterns so that if one

facility, such as Marion, had a special unit for PTSD, then there would be other facilities which would be able to provide the type of follow-up you are talking about.

The treatment teams that have just been established are clinician teams that will basically function in an outpatient setting and will, hopefully, assume follow-up responsibility.

The special committee, in their original report, recommended that each hospital across the United States have a treatment team. We are gradually getting there. It is a little slower than we would like, but many things are. However, I think that progress is being made in that direction.

Mr. JONTZ. That is good to hear. That is what the Gejdenson legislation introduced. It would have required a treatment in each facility.

Now, you know that there are 30 new treatment sites established. I was under the impression that insofar as programs funded by the central office for PTSD—and Marion is not funded by the central office; it is funded from the hospital—that the most recent information I had was that there were only 15 that were central office-funded programs.

Now, when you say treatment sites, I am not sure what that means. Maybe you could kind of lay that out and put this in some perspective for me.

Dr. FALCON. There were 15. This has been expanded with last year's legislation to 30. I think that $5 million was allocated for post-traumatic stress disorder treatment and education delivery. The original 15 sites were reviewed and then there was a final expansion, including—I am not sure where these teams will actually be, the original 15 plus an additional 15 areas.

Now, these will be treatment teams very much like the original 15, only they are somewhat expanded and there is more of an opportunity for accountability back from the local medical center to a central office. There is also a component for the acquisition of data to take a look at how this works, and there is a national data system that is hooked up with these 30 treatment teams.

Mr. JONTZ. Would you be able to make any estimate as to how many other PTSD units there may be that are not central office-funded similar to the Marion?

Dr. FALCON. The vast majority of the units, special treatment units, are different from these teams that we are talking about; these teams are four-person teams that I think you consider to be sort of traveling consultation groups—they are different than a dedicated unit.

There are about 15 units around the country. The majority of these are not funded out of special dedicated central office dollars that I understand. They have been frequently started up on the basis of local interests and have been supported through the RAM in terms of the workload that they generated as their means of support. So, what they really function as,is a general psychiatric unit with a special purpose and, therefore, are supported out of the general funds that are acquired by the hospital.

Mr. JONTZ. Thank you very much. I wish time allowed us to continue this discussion because I am very interested in the work of the committee and your observations.

I do want to thank you for your testimony this morning.

Dr. FALCON. Thank you.

Mr. JONTZ. Let me at this point call forward the remaining witnesses. I think it would be best in the interest of time to ask both of the next two panels to appear as one panel:

David W. Gorman, assistant national legislative director for medical affairs for the Disabled American Veterans; Robert Manhan, special assistant, national legislative service, the VFW; John Bollinger, associate legislative director for Paralyzed Veterans of America; Richard Christian, deputy director, veteran affairs and rehabilitation commission for the American Legion; and Charles Williams, executive director, American Ex-Prisoners of War.

I want to welcome all of you and thank you also for your patience this morning. And perhaps we should proceed in the order in which I read the names.

Mr. Gorman, we will ask you to speak, and we will have all of the statements, and then there may be some questions at that point.

## STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Chairman.

I would like to limit our oral testimony to the two legislative bills on the agenda this morning, and I would first like to talk about the legislation introduced by yourself, Mr. Chairman, H.R. 1780.

This measure proposes to amend Title 38, bringing into conformity eligibility for the provision of outpatient services to that which is stipulated by current law for providing inpatient care to a certain defined universe of veterans.

Simply stated, as we understand it, this measure would, if enacted, mandate the VA to provide outpatient medical services to the same veterans eligible for hospital care, Category A veterans. In our view, the very same logic employed by enacting Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, that mandated the VA to provide inpatient hospital care to a specifically defined category of veterans holds true when one considers the need to be furnished outpatient medical care also.

Mandated entitlement and access to inpatient hospital care does not always meet the veteran's true medical needs. Often, the veteran may only require the less costly mode of outpatient care to stabilize and/or monitor medical conditions for which hospitalization is often unnecessary but may occur if the condition is left to deteriorate.

In our view, Mr. Chairman, this measure will improve veterans' access to outpatient care and will prove medically beneficial, and this bill has the full support of the DAV.

I might also add, Mr. Chairman, that the independent budget document submitted earlier this year also contains this as a legislative initiative and therefore is embraced and endorsed by the organizations in preparation of that budget.

The next issue we would like to discuss is H.R. 1931 as introduced by Mr. Kennedy, the Childless Veterans Assistance Act of 1989. It would also amend Title 38 to add a new subsection authorizing the Secretary at his discretion to provide to an eligible veteran or, if necessary, the veteran's spouse qualifying procreative services and also has provisions for adoption services.

We applaud Mr. Kennedy for his interest and his commitment in pursuing a legislative remedy that would permit a veteran who is unable solely as a result of service-connected disability to become a proud parent. We do feel it unfortunate that the VA continues to hold to the belief, which we believe is mistaken, that they lack the current authority to provide those services under law, as discussed earlier this morning.

The language also limits, under current medical knowledge, what methods of achieving pregnancy are considered to be authorized to be provided as reasonable and necessary to overcome the effects of the veteran's service-connected disability.

However, we continue to be concerned and feel specific language should be set forth expressing the limitations of any measure that may be favorably reported by the subcommittee.

Specifically, we do not envision the VA to be required to provide obstetric services, prenatal, or postnatal care in conjunction with any successfully achieved pregnancy.

We would also raise the issue of the department's potential liability relating to possible complications or permanent disability to the mother or possible birth defects affecting the child.

With those concerns recognized, Mr. Chairman, we are supportive of the provisions of this measure.

That concludes my oral testimony. I would be glad to respond to any questions you may have.

[The prepared statement of Mr. Gorman appears on p. 86.]

Mr. JONTZ. Thank you.

Let's proceed with the other statements.

Mr. Manhan?

## STATEMENT OF ROBERT MANHAN, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. MANHAN. Thank you very much, Mr. Chairman.

There are four issues under consideration this morning. Two address specific ills, and two are broad-gauge philosophical points.

The Veterans of Foreign Wars supports H.R. 1780 and it concurs with a current Veterans of Foreign Wars resolution number 605, which is titled "Entitlement to VA Outpatient Care." Our language is very similar to the language in the bill.

The second bill is Mr. Kennedy's H.R. 1931, and the Veterans of Foreign Wars very strongly supported that philosophy in the Congress last year, and again we are pleased to support Mr. Kennedy's bill this year for procreative assistance and/or adoption assistance for certain married veterans with specific service-connected disabilities.

The first broad-gauged issue under consideration is a comparison of Veterans' Administration versus non-Veterans' Administration health care costs. We already have the benefit of Dr. Gronvall's

earlier testimony, and everything that the VFW is aware of regarding cost does come from the VA. We have always been impressed with how cost efficient VA health care is.

And we also recall that about a month ago, in another subcommittee hearing in this room, we discussed the Department of Defense health care facilities in joint agreements with VA health care facilities. We were consistently told how much money VA facilities saved the Department of Defense.

Having said that, however, the VFW is always considered—is always most interested that all eligible veterans receive the best possible level of health care throughout the VA facilities.

Having said this, we are pleased to point out the fact that we do have a current resolution number 651, titled "Adequate Funding for VA Hospital and Nursing Home Beds," which does require or request that the VA be adequately funded to take care of all veterans' needs.

The last issue under discussion is the effectiveness of budgetary constraints and current resource allocation methods regarding health care in rural areas.

There are two significant factors that work against rural areas. First is economy of scale. It is certainly more cost effective and more efficient to perhaps treat 50,000 to 60,000 patients a year in a rather large facility as opposed to, say, 500 outpatients in a rural facility. So, economy of scale recognizes that, and we have no suggestion of how to overcome it.

The second significant factor is the less attractive, the less desirability of having highly qualified health care people and/or physicians go to rural areas and the predominant disadvantage here is in rural areas health care facilities cannot often link up with large universities and/or the universities' medical facilities.

A suggestion that may be considered here is to have the VA consider the health sharing proviso that is in section 5011 of Title 38, wherein they may want to consider sharing resources, personnel, with any existing hospital in a rural area regardless of the level of funding, whether it be at the national, State, or local level.

The only thing the VFW would insist on is a quid pro quo; that is, that the veteran receive something of equal value in return.

This, in essence, concludes our statement. Thank you, Mr. Chairman.

[The prepared statement of Mr. Manhan appears on p. 90.]

Mr. JONTZ. Thank you very much.

Mr. Bollinger?

## STATEMENT OF JOHN BOLLINGER, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BOLLINGER. Thank you very much, and we thank you for this opportunity to present PVA's views on the issues before us today.

Mr. Jontz, we really appreciate the introduction of H.R. 1780. This legislation assures many veterans access to health care who have neither the necessary private resources or eligibility in other Federal Government health care programs to receive essential medical care.

Expanding eligibility to outpatient care for all Category A veterans we believe is consistent with the trend in modern medicine to develop alternatives to inpatient sources of care. H.R. 1780 expands such outpatient care to those Category A veterans who currently only receive such care in order to obviate the need for inpatient care. Many of these veterans who are chronically ill or medically indigent are particularly vulnerable. Such a patient may have need for ongoing close medical supervision only to be told that hospitalization isn't necessary and, therefore, he is unable to be furnished outpatient care. And sadly, in many of these cases, this person is going to be back at the door of the VA medical facility, requiring expensive and emergency care.

The enactment of H.R. 1780 will ensure that these veterans receive comprehensive, complete outpatient medical services. Unrestricted outpatient care for all Category A veterans would result in better quality of care, reduce the incidence of acute complications, and, in the final analysis, we believe, represents the most efficient use of the medical dollar.

So, we strongly support your legislation.

Next, we deeply appreciate the subcommittee addressing the issue of assistance to veterans who are unable to have children due to a service-connected disability. We are particularly grateful to Representative Joe Kennedy and his staff for introducing this legislation.

This bill means an awful lot to our members, Mr. Chairman. And as you know, we have worked hard over the last number of years to reach acceptable language which results in legislation that would finally make it possible for a service-connected spinal cord-injured veteran to go into a VA hospital and be able to get infertility services and take advantage of the medical technology that exists today.

As you know, the department pays disability compensation for a variety of injuries and diseases that were incurred on active duty. The department provides medical services for these same disabilities. Unlike other compensable disabilities, the department has chosen not to provide medical services to assist a veteran in overcoming a service-connected disability which makes the veteran unable to procreate. It is very difficult for our members to accept this, Mr. Chairman.

With the help of the Congress and the department over the years, we have made great strides in many areas. Spinal cord-injured veterans are living longer, they are living independently. There have been great advancements in architectural designs that provide accessibility.

But the one area where we have come up short is in procreative services, and it is particularly painful because the technology is there. We are simply saying, give those who wish to use such services the opportunity to have a family.

Mr. Kennedy's bill would do just that. And for those who couldn't benefit from infertility services, the bill also contains provisions for reimbursement of certain adoption expenses. I can tell you that our members are very grateful for this legislation. We find it hard to accept the fact that the department whose mission is to rehabilitate and make life better for disabled veterans chooses

to reject this bill. We are very hopeful that agreements will be reached down the road between the various committees and that one day, a spinal cord-injured veteran and his spouse will know the fulfillment of becoming parents, thanks to the medical care provided by the Department of Veterans Affairs.

Regarding cost comparisons of the department and non-DVA health care, I would like to submit for the record, with your permission, a recent PVA publication by Mr. Frank Marone and Dr. Donald Custis regarding Federal health care spending. I think it will be very helpful to the subcommittee.

Among other things, it shows that the DVA system is the best health care bargain in the Nation.

Mr. JONTZ. Without objection, that will be entered into the record.

[The information appears on p. 102.]

Mr. BOLLINGER. That concludes my statement.

[The prepared statement of Mr. Bollinger appears on p. 97.]

Mr. JONTZ. Mr. Christian?

## STATEMENT OF RICHARD CHRISTIAN, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. CHRISTIAN. We recently determined the degree of fiscal year 1989 budgetary shortfalls in a survey on each facility and to assess what the impact that was reported on these funding shortages are having on the provision of medical care to veterans. According to our survey results, the greatest degradation in health care services is being borne by the nondiscretionary workload; specifically, Category B and C veterans.

The American Legion was opposed to the implementation of the means test, from its inception, and we will continue to oppose it.

With respect to H.R. 1780, the American Legion supports the intent of this proposal to expand to some degree outpatient care by making the eligibility criteria consistent with inpatient care.

However, upon review, the language is unclear in this respect: When applying the provisions of section 610, Title 38 U.S. Code to treat all veterans, the budgetary constraints and resource allocation methodologies on the provision of VA care in rural areas is more critical than in urban medical centers which maintain extensive affiliation programs with university medical schools.

The ability of the discretionary workload to successfully be referred to community health services is affected by the degree of available health care resources. Rural VA medical centers which are not affiliated have only a small affiliation program, are reimbursed under current resource allocation methodologies less than large affiliated VA medical centers for the same workload produced.

We believe the provision of VA health care in rural areas is less accessible to the nondiscretionary workload and thus the chance of veterans being successfully referred to local community services in rural areas is considerably less than in urban locations.

It is important for the VA to maintain the vitality of rural medical centers and outpatient clinics so that accessibility to care is similar to that which veterans have in large urban areas.

In comparing the cost of providing VA and non-VA health care, it is difficult to find fully reliable information to use as a guide. We are aware of a VA study completed in May 1986. The main conclusion of the study was that the cost of acute care in VA medical centers is consistent with and comparable to the estimated cost of acute care in non-VA facilities for the same mix of patients.

There is an important difference noted, however. There was an add-on charge in addition to health care costs which are typical in non-VA health care facilities.

THe next item we shall comment on involves draft legislation which would amend section 612 of Title 38 U.S. Code to authorize the Secretary of Veterans' Affairs to provide certain procreative services and reimbursement of certain adoption expenses for married veterans with service-connected disabilities.

There are a relatively limited number of veterans who would be eligible for these services, and even small number who would avail themselves of them. The vast majority of those individuals who would receive this assistance are Vietnam veterans who, without the application of special procedures to overcome the service-connected impairment of their procreative ability, would not be able to parent natural children.

In consideration of these circumstances, we would not oppose the intent of this section.

Mr. Chairman, that completes our statement.

[The prepared statement of the American Legion appears on p. 113.]

Mr. JONTZ. Thank you very much.

We are now ready to finish the testimony, with Mr. Williams' statement.

## STATEMENT OF CHARLES WILLIAMS, EXECUTIVE DIRECTOR, AMERICAN EX-PRISONERS OF WAR

Mr. WILLIAMS. Thank you, Mr. Chairman.

Ladies and gentlemen, it is an honor and a privilege to be able to testify before this committee on such short notice. I will make written testimony available to you shortly to support my oral testimony for the record.

I want to testify today in favor of H.R. 1780. It is a good bill. It is a good bill to correct what every ex-prisoner-of-war I know perceives to be a bad situation.

You see, when Public Law 97-37 was passed, the Veterans' Administration started providing outpatient treatment to all former prisoners-of-war regardless of service connection. This was important to us because of the lack of records that we have from our prison experience. Still after 40-some years, over 50 percent of our members are not service-connected. That is even considering the fact that you good people have passed 15 presumptives for us in the last 7 or 8 years to help establish service connection.

With the passage of Public Law 100-322, and the tight budget we are experiencing, the VA has the tool to turn away nonservice-con-

nected veterans. And I have heard of medical centers where this has happened.

H.R. 1780 would correct all of this. It would again make it possible for all former prisoners-of-war, Mexican border, World War I veterans, and those veterans receiving increased pensions because of the need for regular aid and attendance, that Public Law 100-322 made an optional class of veteran to be treated, to receive that outpatient care that they so desperately need.

Ladies and gentlemen, many of our members were delighted when Public Law 100-322 passed. It gave them three additional presumptives that were badly needed. And for this they were truly grateful.

However, when they found that they had in their minds lost assurance of treatment that they had received in Public Law 97-37, they were surprised. This is the first time, at least to my knowledge, that the Congress has taken away a benefit that it had previously given a group of veterans.

H.R. 1780 is indeed a good move. The American Ex-Prisoners of War will work for its passage.

Mr. Chairman, thank you very much for this opportunity to testify.

Mr. JONTZ. I want to thank all of you for your statements, and I do have a couple of questions.

Mr. Christian, if I understand correctly, your reservation with regard to H.R. 1780 relates to what you perceive as the problem with clarity of language in the bill; is that correct?

Mr. CHRISTIAN. That is correct, Mr. Chairman. We want to make sure that when the bill is written, that it does no harm and knock out any A, B, or C veterans as a result of this passage. Our concern has been that all veterans should be treated.

Mr. JONTZ. I appreciate your concern, and I am sure that counsel can check and make sure that the language of the legislation does do what is intended. And I appreciate your raising that question. I am sure that I can speak for Mr. Kennedy as well as myself in saying thank you all for your statement of support for our legislation, and we do appreciate the testimony in that regard.

Let me ask anyone among you to respond to this question. I had hoped to ask Dr. Gronvall this, and maybe you can give me an answer.

I am under the impression that in fact all Category A veterans were receiving outpatient services up until relatively recently, that although the law did not require, that in fact the VA as a matter of course was doing it.

Our VA outpatient facility had the courtesy to inform me when they decided to cut off B and C veterans and then at a later date had to cut off new admissions of As to the extent that the law allowed them.

But my question is this: Am I mistaken in the impression that in fact virtually all Category A veterans were receiving outpatient services up until the recent budget cuts that have required the VA to look for ways to save money?

Mr. GORMAN. I might start, Mr. Chairman, if I may. When you say up until the time of the present budget cuts, I guess it would have to go back maybe 8 months to a year ago, and prior to that

point I assume your question is directed to. I would have to honestly say that we have not heard or did not hear as many complaints from veterans as far as the denial of provision of outpatient care as we are now.

I think it is safe to say that since about a year ago this time, there have in fact been some veterans classified as Category A veterans who, if not being treated for the service-connected disability, are at least in the 50 percent or more service-connected range were in fact being denied outpatient care, services in outpatient care.

I think that the VA has done an admirable job in getting those patients in and treating them as often as they can, but even the provision in law now about the need for obviating hospitalization provision, I don't think it is being utilized by the hospital directors out in the field. But it is simply being overlooked as unable to be done because of the budget constraints.

So, I think even that provision is not being utilized.

Mr. JONTZ. That provision is mandatory with some categories within Category A. Is that not correct?

Mr. GORMAN. I believe it is correct, but I think that the language—that outpatient care would be provided in order to obviate the need for necessary hospitalization is a matter of judgment being imposed where the hospitalization would not be necessary.

And I think that during the course of the independent budget last year, some conversation was held with a number of hospitals' employees, and that was the consensus that we formed from that exercise.

Mr. JONTZ. Are there other members of the panel that would like to comment on the question?

Mr. WILLIAMS. Let me just say, as I indicated, we perceive or we believe that where they started to deny coverage actually started sometime after Public Law 100–322 was passed. And that was signed into law the 20th of May, as I recall.

However, I am not sure with the Gramm-Rudman-induced cuts and this sort of thing in our budget, that there may not have been a way found to circumvent and start refusing that coverage anyway. I am not sure.

Mr. BOLLINGER. I would like to concur with DAV's comments and also reiterate that the definition of obviate the need has become more restrictive, especially over the last year. More and more of these people not only haven't been able to get treated, but it is taking so much more time to get them treated.

Mr. MONTGOMERY. Okay. I appreciate your response. I have no more questions, and so let me thank you again for your statement.

The subcommittee meeting is now adjourned.

[Whereupon, at 11:09 a.m., the subcommittee was adjourned.]

# APPENDIX

## STATEMENT OF

## HON. G. V. (SONNY) MONTGOMERY, CHAIRMAN

## SUBCOMMITTEE ON HOSPITALS & HEALTH CARE

## APRIL 26, 1989

THE HEARING WILL COME TO ORDER.

GOOD MORNING. THE PURPOSE OF OUR HEARING THIS MORNING IS TO RECEIVE TESTIMONY ABOUT SOME BASIC POLICIES OF THE VETERANS' HEALTH CARE SYSTEM. VETERANS MEDICAL CARE: WHO GETS IT, WHERE DO THEY GET, AND DO THEY GET IT WHEN THEY NEED IT?

FIRST, WE WILL DISCUSS ELIGIBILITY FOR CARE. H. R. 1780 WOULD BRING OUTPATIENT CARE IN LINE WITH HOSPITAL ELIGIBILITY. SECOND, WE WILL DISCUSS RESOURCES FOR CARE AND ACCESS TO CARE. WE WILL DISCUSS FACTORS IN DISTRIBUTING RESOURCES ACROSS THE COUNTRY: RURAL AND URBAN, EVERYDAY CARE AND HIGH-TECH CARE. IN ADDITION, WE WILL DISCUSS THE COSTS OF VETERANS CARE COMPARED TO OTHER DELIVERY SYSTEMS. FINALLY, WE WILL DISCUSS H. R. 1931, A BILL REGARDING CERTAIN PROCREATIVE SERVICES FOR VETERANS.

BY NOW IT SHOULD BE EVIDENT TO EVERYONE THAT THE MEDICAL SYSTEM OF THE DEPARTMENT OF VETERANS' AFFAIRS IS AT A CROSSROADS. THE PATH WE BEGAN ON FORTY YEARS AGO AND STILL TRAVEL TODAY HAS SERVED VETERANS AND THEIR HEALTH CARE NEEDS WELL. BUT BLOCKING THAT PATH ARE BUDGET REALITIES THAT MUST BE CONFRONTED AND OVERCOME IF WE ARE TO MAINTAIN THE COMPREHENSIVE, RESPONSIBLE SYSTEM WE HAVE. THE DECISIONS WE MAKE IN THE NEXT FEW MONTHS WILL HAVE TO BLAZE THE TRAIL FOR THE DEPARTMENT TO TRAVEL OVER THE NEXT DECADES.

HOW DO WE OVERCOME THESE BUDGET PROBLEMS? FIRST WE PUBLICIZE OUR SUCCESSES...WHERE WE'VE BEEN...SO THAT THOSE WHO DETERMINE FUNDING LEVELS CAN FULLY UNDERSTAND THE IMPORTANCE TO THE NATION OF VETERANS HEALTH CARE. SECOND, WE PLAN A STRATEGY FOR THE FUTURE THAT COMPLEMENTS THE OVERALL EFFORT TO DELIVER HEALTH CARE TO THE NATION. IN OTHER WORDS, WE MUST HAVE A GOOD PLAN AND THEN A GOOD PLAN OF ATTACK.

WE HAVE EXPLORED IN PREVIOUS HEARINGS SOME OF THE MOST IMPORTANT PARTS OF THE DEPARTMENT. AT THE BUDGET HEARINGS, WE LEARNED MORE ABOUT THE DEPARTMENT'S CONTRIBUTIONS TO MEDICAL EDUCATION IN THIS COUNTRY AND WE LEARNED ABOUT THE EXCELLENT QUALITY OF CARE FOR VETERANS THAT HAS RESULTED. WE ALSO LEARNED ABOUT THE DEPARTMENT'S RESEARCH THAT HAS MADE BREAKTHROUGHS IN BETTER MEDICAL CARE NOT ONLY FOR VETERANS BUT FOR ALL CITIZENS. WE HAVE LEARNED ABOUT THE DEDICATION OF MEDICAL AND ADMINISTRATIVE STAFF AROUND THE COUNTRY. THEIR JOBS HAVE BEEN TOUGH OVER THE LAST COUPLE OF YEARS.

IN THE COURSE OF THESE DELIBERATIONS, WE HAVE CERTAINLY LEARNED THAT THE DEPARTMENT CANNOT CONTINUE TO PROVIDE MORE CARE WITH LESS DOLLARS. THE WORK OF THIS COMMITTEE IN DOCUMENTING THE BUDGET SHORTFALL AND CUTBACKS WAS CRITICAL. BUT IDENTIFYING THE PROBLEM DOES NOT SOLVE IT.

**TODAY, WE'RE GOING TO EXPLORE SOME OF THE OPTIONS IN ADDRESSING THE FUTURE OF THE VETERANS' HEALTH CARE DELIVERY SYSTEM AND THE PATH IT MUST TAKE IF VETERANS' ARE TO CONTINUE TO RECEIVE NEEDED MEDICAL TREATMENT OF THE HIGHEST QUALITY.**

**OPENING STATEMENT**
**OF**
**THE HONORABLE BOB McEWEN (R-OHIO)**

**SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE**
**HOUSE COMMITTEE ON VETERANS AFFAIRS**
**APRIL 26, 1989**

Thank you, Mr. Chairman.

It is a great pleasure to be here this morning. I am pleased to join my distinguished colleagues on the committee to meet with the respected representatives of some of our most active veterans organizations, because we have an important agenda.

Today, the whole issue of adequate funding for Veterans programs will command the attention of the House of Representatives when Members consider a supplemental appropriation to cover the remainder of the present fiscal year.

The Appropriations Committee and the President each have recognized this pressing need, particularly as it touches our veterans health care system. In a supplemental appropriation which is supposed to address America's most immediate emergency funding needs, I am confident the veterans component is the most legitimate item for inclusion.

We all agree the veterans health care system should have the resources it needs to complete its mission. But we must also frequently examine the costs generated by that system of care, and in the most precise way possible.

While we are fighting for every dime we can find for our strapped veterans medical system, we must be certain each dime is wisely and justly spent. It is our responsibility to be sure VA Medical Centers are serving those people who are deserving, and giving them the care and services which will ease their pain and allow them to live complete, useful lives.

I look for today's panelists to offer direction on how this might be accomplished fairly and efficiently.

STATEMENT OF

HONORABLE JOHN PAUL HAMMERSCHMIDT

THIS SUBCOMMITTEE HAS SPENT CONSIDERABLE TIME THIS CONGRESS DISCUSSING A MULTITUDE OF HEALTH CARE ISSUES THAT HAVE AN EFFECT ON THE NATION'S VETERANS. THE THEME THAT RUNS THROUGHOUT THE COURSE OF DISCUSSIONS OF VETERANS' HEALTH CARE IS ACCESS. THE BIG QUESTION IS "ARE VETERANS GETTING THE SERVICES THEY NEED?"

WE DISCUSSED THE THEME OF ACCESS IN RELATION TO THE DEPARTMENT OF VETERANS AFFAIRS', ON-GOING DIFFICULTIES WITH RECRUITMENT AND RETENTION OF HEALTH PROFESSIONALS. THE SUBCOMMITTEE DETERMINED THAT SHORTAGES OF NURSES ACTUALLY DID IN SOME INSTANCES LEAD TO CLOSURE OF BEDS. OBVIOUSLY, A REDUCTION IN BEDS DOES HAVE AN EFFECT ON ACCESS TO SERVICES.

EARLIER IN THE SESSION, THE FULL COMMITTEE DISCUSSED THE CURRENT BUDGET CRISIS IN THE DEPARTMENT. WE WERE MADE ACUTELY AWARE OF HOW BUDGET INADEQUACIES AFFECT THE ACCESS OF INDIVIDUAL VETERANS TO HEALTH CARE.

TODAY, ONE OF THE BILLS THE SUBCOMMITEE WILL CONSIDER, H.R. 1780, A BILL TO EXPAND ELIGIBILITY FOR OUTPATIENT CARE TO ALL CATEGORY A VETERANS, WOULD IMPROVE ACCESS TO SUCH CARE FOR VETERANS.

ALSO, THE SUBCOMMITTEE WILL TURN ITS ATTENTION TO THE ISSUE OF HEALTH CARE SERVICES TO VETERANS WHO RESIDE IN RURAL AREAS. AGAIN, THE THEME OF ACCESS IS AT THE CENTER OF DISCUSSION.

AND THE SUBCOMMITTEE WILL EXPLORE THE ISSUE OF COST COMPARISON OF DVA MEDICAL CARE AND NON-DVA PROVIDERS OF CARE. THE NOTION THAT DVA HEALTH CARE DOES IN FACT COST LESS IS SOMETHING THAT MANY OF US BELIEVE TO BE TRUE. THE ACTUAL PROOF, HOWEVER, HAS BEEN ELUSIVE. PERHAPS WE WILL BE ABLE TO BETTER UNDERSTAND WHY THIS ISSUE IS SO DIFFICULT TO ASSESS.

THE NATION HAS A COMMITMENT TO MEET THE HEALTH CARE NEEDS OF OUR ELIGIBLE VETERANS. IN TIMES OF BUDGET AUSTERITY, THIS BECOMES AN INCREASINGLY DIFFICULT CHALLENGE. ACCESS TO HEALTH CARE IS THE ROOT OF THIS COMMITMENT AND WE MUST CONTINUALLY MAKE DETERMINATIONS AS TO HOW TO ALLOCATE SCARCE MEDICAL RESOURCES IN AN EQUITABLE MANNER WHICH BEST MEETS THE NEEDS OF THE VETERANS THE SYSTEM HAS BEEN DESIGNED TO SERVE.

THANK YOU MR. CHAIRMAN.

**STATEMENT OF THE HONORABLE J. ROY ROWLAND**

**AT THE HOUSE VETERANS' AFFAIRS**

**SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE HEARING**

**ON H.R. 1780, H.R. 1931 AND OTHER HEALTH CARE MATTERS**

**APRIL 26, 1989**

MR. CHAIRMAN, I WANT TO COMMEND YOU FOR ARRANGING THIS HEARING TODAY AND FOCUSING IN ON SOME EXTREMELY IMPORTANT ISSUES. TWO OF THE SUBJECTS WE WILL COVER ARE OF PARTICULAR INTEREST TO ME: THE COST OF CARE PROVIDED IN THE VA AS COMPARED TO NON-VA CARE AND THE ACCESSIBILITY OF THAT CARE.

I HAVE LONG CONTENDED THAT THE VA PROVIDES QUALITY CARE IN A MORE COST-EFFICIENT MANNER THAN NON-VA PROVIDERS. AS WE DISCUSSED AT OUR LAST HEARING, DURING THE LAST 10 YEARS THE VA BUDGET HAS BEEN STRAIGHT LINE, YET THE NUMBER OF IN-PATIENTS TREATED HAS INCREASED BY 7 PERCENT, THE NUMBER OF OUT-PATIENTS HAS INCREASED BY 29 PERCENT, AND THE NUMBER OF LONG-TERN-CARE PATIENTS BY 60 PERCENT. SO WHILE PATIENT LOADS INCREASED AT OUR VA HOSPITALS, THE VA WAS STILL ABLE TO PROVIDE QUALITY CARE TO VETERANS WITHOUT COMPARABLE INCREASES IN FUNDING.

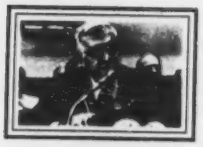
I WILL BE INTERESTED IN LEARNING FROM OUR WITNESSES THE STATUS OF ANY ONGOING COST-COMPARISONS. I BELIEVE THAT THIS IS SOMETHING THAT WOULD BE VERY VALUABLE FOR US TO PURSUE AND COULD HELP US ALLEVIATE SOME OF THE BUDGET CONSTRAINTS THE VA FACES. FOR IF IT IS THE CASE THAT THE VA IS MORE COST EFFECTIVE IN PROVIDING CARE THAN NON-VA SOURCES, IT MAY ACTUALLY COST THE GOVERNMENT MORE MONEY OVERALL WHEN REDUCING FUNDING FOR VA HEALTH CARE. THIS IS BECAUSE MANY VETERANS WHEN TURNED AWAY FROM THE VA WILL SIMPLY RELY ON OTHER MORE EXPENSIVE GOVERNMENT PROVIDERS.

SECONDLY, I AM VERY CONCERNED ABOUT THE ABILITY OF OUR VETERANS TO RECEIVE QUALITY CARE IN RURAL AREAS. THE RURAL VETERAN MUST OFTEN TRAVEL HUNDREDS OF MILES TO REACH A VA HOSPITAL. WHEN THESE RURAL HOSPITALS ARE TARGETED FOR PARTIAL CLOSURE OR DOWNSIZING, IT CAN CAUSE A DOMINO-LIKE EFFECT. RECRUITMENT AND RETENTION OF STAFF WILL SUFFER AND THIS WILL IMPACT ON THE OVERALL PERFORMANCE OF THE HOSPITAL.

FINALLY, I WOULD LIKE TO MAKE A COUPLE BRIEF COMMENTS ABOUT THE LEGISLATIVE PROPOSALS WE ARE CONSIDERING TODAY. I UNDERSTAND THAT THERE ARE CONCERNS WITH REGARD TO THE COST OF H.R. 1780, RELATING TO OUTPATIENT CARE. IT SEEMS TO ME HOWEVER, THAT IF OUTPATIENT COSTS ARE INCREASED BY THE NEW ENTITLEMENTS THAT H.R. 1780 PROPOSES, THAT THESE MAY BE OFFSET BY THE DECREASED HOSPITAL COSTS THAT THE BILL COULD BRING ABOUT.

I AM A COSPONSOR OF H.R. 1931, AND I WANT TO COMMEND MY COLLEAGUE JOE KENNEDY FOR INTRODUCING THIS IMPORTANT LEGISLATION. BY PROVIDING PROCREATIVE SERVICES, IT SEEMS TO ME THAT THE VA WOULD SIMPLY BE CONTINUING A POLICY OF PROVIDING OVERALL CARE TO OUR VETERANS. I THINK THAT WE SHOULD CERTAINLY DO ALL THAT WE CAN TO HELP THE VETERAN, WHO BECAUSE OF HIS OR HER SERVICE TO OUR COUNTRY, INCURRED AN INJURY WHICH PREVENTS THEM FROM HAVING A FAMILY.

THANK YOU AGAIN MR. CHAIRMAN, I LOOK FORWARD TO THE TESTIMONY OF OUR WITNESSES.



# news release

## Congressman TOM LEWIS

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**Statement of The Honorable Tom Lewis**
**Before the Subcommittee on Hospitals and Health Care**
**April 26, 1989**

Thank you, Mr. Chairman, for the opportunity to testify in strong support of the nursing home portion of the Department of Veterans Affairs Palm Beach Medical Center. I think it is quite apparent we all agree this nursing home is badly needed.

The original design of the Medical Center called for a 625-bed hospital along with a 240-bed nursing home. Since the area's veteran population is rapidly aging, and the need for the hospital beds is declining, the Veterans Administration made a decision, which I supported, to cut the hospital beds from 625 to 400 while maintaining their commitment to the Nursing Home.

The rapid aging of South Florida's Veterans has served to reinforce my belief in the importance of a nursing home to serve the many elderly veterans in this area. The South Florida area affected by this Medical Center has well over 200,000 Veterans at the present time, with more moving in every day. At the present time, the only nursing home for South Florida's Veterans is the 212 bed facility in Miami. This facility is simply too small. And too far away for the Veterans outside Dade and Monroe counties.

A study by the Veterans Administration itself indicates four or five times the current nursing home beds are needed by Florida's Veterans. Go figure why the VA would not ask for this nursing home. Not only did they not ask once, they did not ask twice!

Last year, you may recall that the Administration did not request the nursing home. Your committee, realizing its importance, placed it back in the budget. I commend the Committee for doing so again. Obviously the Committee shares my belief that this Nursing Home is indispensable to the elderly Veterans of Florida.

We cannot ignore the long-term health care needs of those men and women who gave so much of themselves to protect our nation in its time of need. There is an undeniable need for the nursing home as an integral part of this medical center. Eliminating it closes the door on the greatest test this country faces in its commitment to our aging veterans.

In closing, I urge this Committee to pass this legislation containing the nursing home for the Palm Beach Medical Center, and I would like to thank this Committee for the opportunity to testify. As a Veteran myself, I have long been interested in this Committee's concerns, and have always enjoyed working with this Committee to ensure that our Veterans are treated fairly.

STATEMENT OF

JOHN A. GRONVALL

CHIEF MEDICAL DIRECTOR

BEFORE THE

SUBCOMMITTEE ON HOSPITALS

AND HEALTH CARE

HOUSE VETERANS AFFAIRS COMMITTEE

APRIL 26, 1989

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here this morning to testify in connection with your oversight into several important health care issues and to offer views on two legislative proposals under consideration.

H.R. 1780

As you know, Mr. Chairman, with the enactment of Public Law 100-322, Congress provided for the first time that VA "shall" furnish outpatient care to certain categories of veterans.

P.L. 100-322 directed that VA provide outpatient treatment, without limitation, to any veteran needing care for a service-connected condition and for any disability of any veteran who is 50% or more service-connected disabled. It also mandated that for any service-connected veterans who are 30% or 40% disabled and any other veteran whose annual income is below the maximum annual rate of pension, VA "shall" provide outpatient treatment in preparation, or to obviate the need, for hospital admission as well as to complete treatment initiated during inpatient care.

H.R. 1780 would significantly enlarge the group of veterans to whom VA "shall" provide comprehensive outpatient treatment to include all so-called "category A" veterans.

Viewed solely from an administrative perspective, there may be some merit to the concept of a common eligibility framework for all VA medical benefits, subject to differing priorities among eligible veterans. However, we do not support simply enlarging the class of veterans to whom VA "shall" provide comprehensive outpatient treatment, as proposed, particularly in light of the recent bipartisan "summit" agreement on the outlines of the FY 90 budget.

The proposed changes would certainly be far-reaching in nature. While we are not able to offer you at this time a

comprehensive analysis of its impact, we do project that enactment of such a provision would entail additional costs to VA in excess of $1 billion annually.

DRAFT LEGISLATION

Mr. Chairman, you have also sought our views on a draft bill that would authorize VA to furnish certain "procreative services" and payment of certain adoption expenses for veterans qualifying under the bill. We do not support enactment of this proposal. Without attempting to describe the bill's provisions in detail, we note that it would limit the scope of qualifying services by specifically ruling out, for example, in vitro fertilization and the services of a surrogate mother. It would authorize VA to pay up to $2,000 for expenses incurred in adopting a child and to limit total payments to any one veteran to $4,000. The bill would appear to authorize payments for expenses incurred in any legal adoption, including adoptions through a "private placement."

The bill would authorize VA to provide these services to any married veteran who has a service-connected disability which impairs the ability of the veteran or spouse to conceive a child.

Receipt of the legislation only last week has given us only limited opportunity to study its implications. We do note, in

relation to prior legislation before this committee, that the measure narrows the scope of "procreative services" services VA could furnish. Our preliminary analysis suggests, however, that it raises some of the same philosophical, ethical and practical issues we have confronted in prior legislation. As you know we have withheld our support from legislation which we viewed as placing VA in the position of regulating access to reproductive technology in the absence of societal consensus on the propriety of such a governmental role. Thus, while we are certainly supportive of making efficacious medical technology available to our veterans, we cannot escape the fact that authorizing procreative services represents more than simply providing a new service to veterans.

The bill also proposes for the first time that the VA subsidize adoption expenses for eligible veterans. Again, we must caution that the limited time we have had to respond to your request to testify has not afforded much opportunity to reflect on this far-reaching proposal. The implications, however, regarding the establishment of such a benefit are not insignificant.

Providing for such a benefit would take VA well beyond its longstanding role, as regards the service-connected disabled veteran, of providing compensation and benefits for that disability. Indeed, its aim goes well beyond the purposes

served by other benefits established through the initiative of this subcommittee. The Department of Veterans Affairs is not prepared at this time to endorse that concept.

OVERSIGHT ISSUES

Mr. Chairman, also on today's agenda is the question of how VA costs compare with private sector health care costs. The first comparative study of VA and community health care delivery systems arose from the National Academy of Science's 1977 report, "Health Care for American Veterans." This first comparison of VA and community medical systems for episodes of acute inpatient medical and surgical care was based on reported per diem expenses. The report was published in 1977. VA staff updated that study in reports in 1980 and 1982. The 1982 revision incorporated cost comparisons of VAMCs with community hospitals affiliated with medical schools, and attempted to compare costs in a specific locality. These studies concluded that the cost of VA care ranged from slightly less expensive to significantly less expensive than reported private sector costs of care.

General Accounting Office (GAO) review of the 1980 study criticized the cost comparison methodology, but at the time VA disagreed with many of those criticisms. The GAO focused on the study's inability to compare accurately several component services. For example, unlike VA medical centers, community hospitals usually do not provide such services as audiology, optometry, blind rehabilitation or VA beneficiary travel allowances. These costs were "buried" in overall reported VA costs. Problems of costs versus charges in the private sector added another dimension to questions of validity of the study's findings. GAO noted that the cost comparison methodology failed to take account of differences in the ways physician costs are dealt with in the VA versus private hospitals. Similiarly, it did not consider costs of capital, which substantially influence cost of care and financial management of private hospitals, but generally do not in VA medical centers. GAO contended a more accurate and meaningful comparison of VA with non-VA costs required a similar accounting technique for VA capital costs, including depreciation and amortization of plant and equipment, headquarters administrative expenses, interest, debt and like matters. The VA's 1982 revision of the 1980 study attempted to deal more directly with these GAO criticisms. GAO did not, to our knowledge, officially review the 1982 revision.

In 1984, at the request of the White House Working Group on Health Policy and Economics, we attempted to conduct a more sophisticated cost comparison study, also sensitive to the prior GAO criticisms and using new data based on diagnosis-related groups (DRG). We compared similar groupings--e.g., VA medical centers in Maryland and Utah with private sector facilities in those States; our experience in providing care to veterans over the age of 65 against patients receiving care under Medicare sponsorship in private hospitals, etc. Comparisons were made by DRG and by major categories of care. All prior criticisms were either dealt with in the methodology, or the study authors expressed assumptions, caveats and disclaimers within the body of the study itself. The results, which were published in 1986, indicated VA costs were generally significantly less than most community hosptials were currently charging patients for similar types of care. The data and analysis supported the study's conclusion that VA costs were comparable to, and consistent with, estimated costs in the private sector, but were significantly less than private hospitals' claimed charges for care.

This most recent study was provided to two expert consultants prior to publication. Dr. Stephen Graves of MIT and Dr. Duncan Neuhauser of Case Western Reserve University, both highly respected health economists, commented that the 1986 study was an improved methodology from prior VA efforts to compare our

costs with others'. However, they saw continuing difficulties in even this, more sophisticated, methodology. For example, certain cost elements still were not adequately taken into account. Of their specific interest were costs of capital and support to medical education. [The study had attempted to deal with capital issues by adding 11.4% to average reported VA costs. This was the best estimate available at the time, but was not wholly satisfactory to the task of accounting for capital.] These consultant reviewers also expressed concern that the methodology did not account for differences in quality of care. Further, they saw flaws in the methodology in that it of necessity relied on data files--VA's on the one hand, private sector facilities' and systems' and the Health Care Financing Administration's (HCFA) on the other--which were constructed for entirely different purposes and thus were constructed entirely differently.

As suggested by several reviewers of these studies, identifying the "cost per case" is still an elusive goal. This would pertain also to studies comparing VA costs to those of the community at large in programs such as ambulatory, nursing home, or other forms of extended care, were such studies attempted. No methodology has yet been devised which will help disclose real, per-case costs.

Thus, Mr. Chairman, the definitive answer is not yet at hand as to whether the cost of care in the VA system is less than that in the private sector. One of our consultants in 1986 did propose a theoretically reliable means of accurately comparing VA and private sector costs of care. He recommended a random assignment of VA patients to private sector and VA facilities, with follow-on comparisons of costs to the VA and the quality of care received in each instance. Setting aside the broad policy issues such an idea raises, VA's sending patients to community hospitals would not in itself, of course, assure us of obtaining from all those facilities sufficient data to determine the true cost of care, versus claimed charges. Assuming a basis of accurate comparison would be feasible, achieving it would require collaboration and agreement among cost analysis experts in the VA; HCFA; outside health care finance and accounting experts; the American Hospital Association and other multi-hospital associations and groups; third party payors, and perhaps many others, to reach consensus on pertinent assumptions, definitions and the myriad problems associated with comparability. In our pluralistic medical system, such collaboration is not always easy to achieve. As an illustration, in our 1986 study, we needed to obtain a data file from a large city's publicly funded hospital system. When its officials learned our cost comparison would likely be published and might become public knowledge--even though we assured them of anonymity, they refused to grant permission for us to use the system's records in our study.

As a final point on cost comparisons, I would be remiss not to say that any studies to be performed should not only investigate the question of whether VA care is cost effective, but should also be used to help assure that it remains of high quality.

## RURAL HEALTH CARE

Mr. Chairman, you have also asked us to discuss the effects of budgetary constraints and resource allocation methods on the provision of care in rural areas. The current resource allocation methodology, or RAM, is neutral with respect to the provision of health care in rural areas. During the first years use of the RAM, when all facilities competed against one another within a single pool of resources, we adopted a policy of limiting the gains of small, unaffiliated facilities. These facilities, which tend to be situated in rural areas, appeared highly efficient as measured by the RAM and, therefore, generally earned amounts disproportionate to their size. This appearance of great efficiency was thought to be an artifact of their small size and lack of residency training rather than a reflection of superior methods of operation. Two years ago, we

restructured the RAM so that facilities of comparable size, affiliation status, and mission would compete against one another within six hospital groups. Small facilities are divided into affiliated and unaffiliated categories and compete against one another within their respective groups. We believe that this change has eliminated any bias that the previous model had concerning the rural/urban factors.

The Veterans Health Services and Research Administration's comprehensive network of health care facilities includes 172 medical centers, many of which are located in remote, rural areas. That network also includes a wide range of ambulatory care services provided through VHS&RA medical center clinics, free standing independent clinics, satellite clinics, and outreach programs. The smaller community-based clinics and outreach programs are especially designed to improve access to health care for veterans who live in areas of considerable distance from VHS&RA facilities where manpower resources are scarce.

Also, various other service delivery mechanisms have been developed to improve access to VHS&RA health care services. These mechanisms, developed to surmount access barriers, and found in service areas across the country, include:

-- Arrangements with public or private agencies under which we provide treatment or counseling in leased or

borrowed space, as well as more conventional sharing agreements under which community providers furnish specialized medical services to veterans;

-- Authorization of fee-basis care and contract hospital care where VHS&RA cannot provide services to certain categories of veterans;

-- Contracts with community nursing home facilities;

-- Use of community residential care homes;

-- Sharing agreements with the Department of Defense to use military facilities, resources, and medical expertise where appropriate to treat veteran patients;

-- Provision of per diem payments and construction grants for state nursing home and domiciliary care;

-- Hospital Based Home Care in which a team of clinical staff from a VHS&RA medical center provides regular health care in patients' homes;

-- Group therapy or counseling held in community settings by mental health staff or veteran representatives, e.g., readjustment counseling;

-- Use of field social workers, visual impairment service teams, and mental health personnel to visit veterans in their homes; and,

-- A Beneficiary Travel Program in which veterans are reimbursed for their travel expenses to VHS&RA facilities.

In addition to the VHS&RA network of health care facilities, and authorized community health care, several special rural care initiatives are being undertaken as well. For instance, two pilot demonstration projects have been implemented this past year to identify alternatives for special access problems of remote, rural areas. The two demonstrations are located in the four corners area of Northwestern New Mexico and the northernmost counties of California. One is a joint endeavor with a local community clinic in Farmington, New Mexico. The other is a community-based clinic for primary care and hospital follow-up in Redding, California. The clinics are being evaluated in terms of improving access to health care, the quality and cost of services, and satisfaction of veterans.

A survey of VHS&RA outpatient activities conducted in July, 1988 indicates that over 200 outpatient activities were held away from medical centers during FY 1987. Many of these activities were in the form of small clinics and outreach

programs to provide services to veterans in rural areas. Various types of outreach programs were identified, with the predominant one being mobile teams, followed by outposts with a minimal staff for follow-up care and referral. A significant increase in outpatient activities held in areas away from VHS&RA medical centers has occurred, particularly in the past three years.

We believe that the VHS&RA's network of inpatient and outpatient facilities, and the multiple initiatives sponsored by these facilities in the past few years, has substantially addressed the needs of veterans living in rural areas.

Mr. Chairman, that completes our formal testimony. My colleagues and I would be pleased to respond to any questions you may have.

## COST ESTIMATION WORKSHEET

LEGISLATION NUMBER/NAME: H.R.1780 To Revise The Eligibility for Outpatient Medical Services

SUB-TITLE NUMBER/NAME:

SECTION NUMBER/NAME: (Total Cost of Attachments A, B, C )

I. 6-YEAR COST ESTIMATION: (Dollars in Millions)

| | FY89 | FY90 | FY91 | FY92 | FY93 | FY94 | TOTAL |
|---|---|---|---|---|---|---|---|
| (a) TOTAL COST(000,000s): | - | 1333.6 | 1333.6 | 1333.6 | 1333.6 | 1333.6 | 6668.0* |
| (b) FTEE: | - | 22,417 | 22,417 | 22,417 | 22,417 | 22,417 | 22,417 |
| (c) DOLLAR AUTHORIZATION SPECIFIED IN BILL (IF ANY)(000s): | - | 0 | 0 | 0 | 0 | 0 | 0 |
| (d) ADD'L APPROPRIATION REQD(000,000s): | - | 1333.6 | 1333.6 | 1333.6 | 1333.6 | 1333.6 | 6668.0* |
| (e) WORKLOAD (Units = Visits or ADC): | See below for yearly workload. | | | | | | |

II. ASSUMPTIONS & METHODOLOGY OF COST, FTEE, & WORKLOAD PROJECTIONS: Use a COST ESTIMATION (Continuation) WORKSHEET for additional space.

For assumptions and methodology see Attachment D.

Methodology used in FTEE -

| | Factor | FTEE |
|---|---|---|
| Total Outpatient visits, each year = 12,034,200 | x .00165 = | 19,856 |
| Total VA Hospital ADC, each year = 701.3 | x 2.52 = | 1,767 |
| Total VA Nursing ADC, each year = 650.7 | x 1.22 = | 794 |
| Total Community Nursing ADC, each year = 438.1 | No FTEE | |

Total FTEE = 22,417

*The cost estimates do not include construction costs for new facilities that would be required to accommodate additional workloads as described in this cost estimate. These costs could be as high as $800,000,000 over the 5-year period.

III. NAME OF RESPONSIBLE SERVICE/PROGRAM: Reports and Statistics (10A42) DATE: June 29, 1989

STAFF CONTACT PERSON: Norman Miller TELEPHONE: 233-6920

COST ESTIMATION WORKSHEET — Attachment A

LEGISLATION NUMBER/NAME: H.R.1780 To Revise The Eligibility for Outpatient Medical Services

SUB-TITLE NUMBER/NAME:

SECTION NUMBER/NAME: (Veterans on Pension)

I. 6-YEAR COST ESTIMATION: (Dollars in Millions)

| | FY89 | FY90 | FY91 | FY92 | FY93 | FY94 | TOTAL |
|---|---|---|---|---|---|---|---|
| (a) TOTAL COST(000,000s): | - | 243.7 | 243.7 | 243.7 | 243.7 | 243.7 | 1218.5 |
| (b) FTEE: | - | 4,084 | 4,084 | 4,084 | 4,084 | 4,084 | 4,084 |
| (c) DOLLAR AUTHORIZATION SPECIFIED IN BILL (IF ANY)(000s): | - | 0 | 0 | 0 | 0 | 0 | 0 |
| (d) ADD'L APPROPRIATION REQD(000,000s): | - | 243.7 | 243.7 | 243.7 | 243.7 | 243.7 | 1218.5 |
| (e) WORKLOAD (Units = Visits or ADC): | See below for yearly workload. | | | | | | |

II. ASSUMPTIONS & METHODOLOGY OF COST, FTEE, & WORKLOAD PROJECTIONS: Use a COST ESTIMATION (Continuation) WORKSHEET for additional space.

For assumptions and methodology see Attachment D.

Methodology used in FTEE -

| | | Factor | FTEE |
|---|---|---|---|
| For Pension outpatient visits, each year = | 2,232,900 | x .00165 = | 3,684 |
| For Pension VA Hospital ADC, each year = | 109.5 | x 2.52 = | 276 |
| For Pension VA Nursing ADC, each year = | 101.6 | x 1.22 = | 124 |
| For Pension Community Nursing ADC, each year = | 68.4 | No FTEE | |
| | | Total FTEE = | 4,084 |

III. NAME OF RESPONSIBLE SERVICE/PROGRAM: Reports and Statistics (10A42) DATE: June 9, 1989

STAFF CONTACT PERSON: Norman Hiller TELEPHONE: 233-6920

COST ESTIMATION WORKSHEET

Attachment B

LEGISLATION NUMBER/NAME: H.R.1780 To Revise The Eligibility for Outpatient Medical Services

SUB-TITLE NUMBER/NAME:

SECTION NUMBER/NAME: (Service-Connected Veterans Rated Less Than 50 Percent)

I. 6-YEAR COST ESTIMATION:
(Dollars in Millions)

| | FY89 | FY90 | FY91 | FY92 | FY93 | FY94 | TOTAL |
|---|---|---|---|---|---|---|---|
| (a) TOTAL COST(000,000s): | - | 630.8 | 630.8 | 630.8 | 630.8 | 630.8 | 3154.0 |
| (b) FTEE: | - | 10,651 | 10,651 | 10,651 | 10,651 | 10,651 | 10,651 |
| (c) DOLLAR AUTHORIZATION SPECIFIED IN BILL (IF ANY)(000s): | - | 0 | 0 | 0 | 0 | 0 | 0 |
| (d) ADD'L APPROPRIATION REQD(000,000s): | - | 630.8 | 630.8 | 630.8 | 630.8 | 630.8 | 3154.0 |
| (e) WORKLOAD (Units = Visits or ADC): | See below for yearly workload. | | | | | | |

II. ASSUMPTIONS & METHODOLOGY OF COST, FTEE, & WORKLOAD PROJECTIONS: Use a COST ESTIMATION (Continuation) WORKSHEET for additional space.

For assumptions and methodology see Attachment D.

Methodology used in FTEE -

| | | Factor | FTEE |
|---|---|---|---|
| For SC LT 50% outpatient visits, each year = 5,553,600 | x | .00165 = | 9,163 |
| For SC LT 50% VA Hospital ADC, each year = 407.6 | x | 2.52 = | 1,027 |
| For SC LT 50% VA Nursing ADC, each year = 378.1 | x | 1.22 = | 461 |
| SC LT 50% Community Nursing ADC, each year = 254.6 | | No FTEE | |

Total FTEE = 10,651

III. NAME OF RESPONSIBLE SERVICE/PROGRAM: Reports and Statistics (10A42) DATE: June 9, 1989

STAFF CONTACT PERSON: Norman Hiller TELEPHONE: 233-6920

COST ESTIMATION WORKSHEET

Attachment C

LEGISLATION NUMBER/NAME: H.R.1780 To Revise The Eligibility for Outpatient Medical Services

SUB-TITLE NUMBER/NAME:

SECTION NUMBER/NAME: ((Non Service-Connected Veterans ( Category A) (NSC))

I. 6-YEAR COST ESTIMATION: (Dollars in Millions)

| | FY89 | FY90 | FY91 | FY92 | FY93 | FY94 | TOTAL |
|---|---|---|---|---|---|---|---|
| (a) TOTAL COST(000,000s): | - | 459.1 | 459.1 | 459.1 | 459.1 | 459.1 | 2295.5 |
| (b) FTEE: | - | 7,682 | 7,682 | 7,682 | 7,682 | 7,682 | 7,682 |
| (c) DOLLAR AUTHORIZATION SPECIFIED IN BILL (IF ANY)(000s): | - | 0 | 0 | 0 | 0 | 0 | 0 |
| (d) ADD'L APPROPRIATION REQD(000,000s): | - | 459.1 | 459.1 | 459.1 | 459.1 | 459.1 | 2295.5 |

(e) WORKLOAD (Units = Visits or ADC): See below for yearly workload.

II. ASSUMPTIONS & METHODOLOGY OF COST, FTEE, & WORKLOAD PROJECTIONS: Use a COST ESTIMATION (Continuation) WORKSHEET for additional space.

For assumptions and methodology see Attachment D.

Methodology used in FTEE -

| | Factor | FTEE |
|---|---|---|
| NSC Cat A outpatient visits, each year = 4,247,700 | x .00165 = | 7,009 |
| NSC Cat A VA Hospital ADC, each year = 184.2 | x 2.52 = | 464 |
| NSC Cat A VA Nursing ADC, each year = 171.0 | x 1.22 = | 209 |
| NSC Cat A Community Nursing ADC, each year = 115.1 | No FTEE | |

Total FTEE = 7,682

III. NAME OF RESPONSIBLE SERVICE/PROGRAM: Reports and Statistics (10A42) DATE: June 9, 1989

STAFF CONTACT PERSON: Norman Hiller TELEPHONE: 233-6920

RATIONALE

H.R. 1780

Three bases: Pensioners; SC less than 50% Disabled; NSC Category A--All data on populations, use rates and costs are from FY 1988 End of Year Reports

PENSIONERS:

| | | |
|---|---|---|
| Total Population: | 605,527 | |
| Currently in Receipt of Care | 253,669 | (41.9%) |
| Not-Currently in Receipt of Care | 351,858 | |

Assumptions:

1. Since the pensioners currently in receipt of care will now be eligible for long-term chronic care on an outpatient basis, their visit rate will now approximate that of the SC greater than or equal to 50%, i.e,, it will increase from 9.0 to 13.4 visits per person per year.

2. Pensioners not currently in receipt of care will come to the VA at the same percentage experienced by current users.

3. Fourteen percent (14%) of pensioners not currently in receipt of care will not chose to use the VA because of distance from a VA facility and/or because of waiting time.

4. Current users will only use outpatient care while new users will use in addition to VA outpatient care, VA hospital care, VA nursing home care and community nursing home care.

Current Users:

Visits: 253,699*(13.4 - 9.0) or 1,116,276
Dollars: 1,116,276*$100.12 or $111.8 million

New Users

Persons: 351,858*(1.00 - 0.14)*0.41 or 124,065

Visits: 124,065*9.0 (current user rate) or 1,116,587
Dollars: 1,116,587*$100.12 or $111.8 million

VA Hospitals: 124,065*.018 (Veterans using VA hospital care as a percent of all veterans) or 2,233
Dollars: 2,233*17.9 (current average length of stay)*$323.63 (dollars per day) or $12.9 million.

PENSION CONTINUED

VA nursing homes: 124,065*.00122 (Veterans using VA nursing home as a percent of all veterans) or 151.4
Dollars: 151.4*245 (current average length of stay)*$139.85 (dollars per day) or $5.2 million

Community nursing 124,065*.00148 (Veterans using community nursing as a percent of all veterans) or 183.6
Dollars: 183.6*136 (current average length of stay) *$78.84 (dollars per day) or $2.0 million

SC LESS THAN 50% DISABLED

| | | |
|---|---|---|
| Total Population: | 3,236,389 | |
| Currently in Receipt of Care | 679,802 | (21.0%) |
| Not Currently in Receipt of Care | 2,556,587 | |

Assumptions:

1. Since SC Less Than 50% currently in receipt of care will now be eligible for long-term chronic care on an outpatient basis and because they represent a less disabled group than the SC greater than or equal to 50%, their increase in visit rate is approximated as being halfway between that of the SC greater than or equal to 50% and that of the SC less than 50% (13.4 - 8.2)/2 or 2.6 visits i.e., the SC less than 50% rate will increase from 8.2 to 10.8 visits per person per year.

2. The SC less than 50% not currently in receipt of care will come to the VA at the same percentage experienced by current users.

3. Fourteen percent (14%) of the SC less than 50% not currently in receipt of care will not chose to use the VA because of distance from a VA facility and/or because of waiting time.

4. Current users will use outpatient care but at an increased rate while new users will use in addition to VA outpatient care, VA hospital care, VA nursing home care and community nursing home care.

Current Users:

Visits: 679,802*2.6 or 1,767,485
Dollars: 1,767,485*$100.12 or $177.0 million

New Users

Persons: 2,556,587*(1.00 - 0.14)*0.21 or 461,720

Visits: 461,720*8.2 (current user rate) or 3,786,101
Dollars: 3,786,101*$100.12 or $379.1 million

SC LESS THAN 50% CONTINUED

VA Hospitals: 461,720*.018 (Veterans using VA hospital care as a percent of all veterans) or 8,311
Dollars: 8,311*17.9 (current average length of stay)*$323.63 (dollars per day) or $48.1 million.

VA nursing homes: 461,720*.00122 (Veterans using VA nursing home as a percent of all veterans) or 563.3
Dollars: 563.3*245 (current average length of stay)*$139.85 (dollars per day) or $19.3 million

Community nursing 461,720*.00148 (Veterans using community nursing as a percent of all veterans) or 683.3
Dollars: 683.3*136 (current average length of stay) *$78.84 (dollars per day) or $7.3 million

NON SERVICE CONNECTED CATEGORY A

| | |
|---|---|
| Total Population | 27,200,000 |
| All Service Connected and Pensioners | 4,300,000 |
| Difference | 22,900,000 |
| Less Fourteen Percent (see Pensioners, assumptions paragraph 3.) | 19,694,000 |

Assumption: Of the remaining difference, it is reasonable to assume that 10% will qualify for medical benefits under the HR-1780 provisions.

About 10-15% of the total veteran population is "poor" by some definition. Taking the more conservative figure of these ranges, we estimate 10% of all NSC veterans would potentially become "qualified" for these new benefits. Thus,

| | |
|---|---|
| Total eligible NSC A's (10% of 19,694,000) | 1,969,400 |
| Current users | 975,400 |
| New Potential Users (difference) | 994,000 |

We further assume approximately twenty one percent (the same percent as the SC less than 50% ) of the potential users --994,000 individuals-- would in fact use VA services. Also, that current users will increase their visit rate by 2.6 which is the same for SC less than 50%.

Current Users:

Visits: 975,400*2.6 or 2,536,040
Dollars: 2,536,040*$100.12 or $253.9 million

New Users

Persons: 994,000*0.21 or 208,740

Visits: 208,740*8.2 (current SC less than 50% user rate) or 1,711,668

Dollars: 1,711,668*$100.12 or $171.4 million

NSC CONNECTED CATEGORY A CONTINUED

VA Hospitals: 208,740*.018 (Veterans using VA hospital care as a percent of all veterans) or 3,757

Dollars: 3,757*17.9 (current average length of stay)*$323.63 (dollars per day) or $21.8 million.

VA nursing homes: 208,740*.00122 (Veterans using VA nursing home as a percent of all veterans) or 254.7

Dollars: 254.7*245 (current average length of stay)*$139.85 (dollars per day) or $8.7 million

Community nursing 208,740*.00148 (Veterans using community nursing as a percent of all veterans) or 308.9

Dollars: 308.9*136 (current average length of stay) *$78.84 (dollars per day) or $3.3 million

Summary of the Number of Veterans Users Under the Provisions of HR-1780

Number of Veterans (000's)

| | Current | New | Total | Percent New |
|---|---|---|---|---|
| Pensioners | 254 | 124 | 378 | 32.8 |
| SC GE 50% | 293 | 0 | 293 | 0.0 |
| SC LT 50% | 680 | 462 | 1142 | 40.5 |
| NSC-A | 975 | 209 | 1184 | 17.7 |
| Total | 2202 | 795 | 2997 | 26.5 |

## Summary of the Estimated Workload for HR-1780

Visits(000's)/Average Daily Census

Current Users

| Program Type | Pension | SC LT 50% | NSC Cat A | Total |
|---|---|---|---|---|
| VA Outpatient | 1116.3 | 1767.5 | 2536.0 | 5419.8 |
| VA Hospital | 0.0 | 0.0 | 0.0 | 0.0 |
| VA Nursing | 0.0 | 0.0 | 0.0 | 0.0 |
| Community Nursing | 0.0 | 0.0 | 0.0 | 0.0 |

Visits(000's)/Average Daily Census

New Users

| Program Type | Pension | SC LT 50% | NSC Cat A | Total |
|---|---|---|---|---|
| VA Outpatient | 1116.6 | 3786.1 | 1711.7 | 6614.4 |
| VA Hospital | 109.5 | 407.6 | 184.2 | 701.3 |
| VA Nursing | 101.6 | 378.1 | 171.0 | 650.7 |
| Community Nursing | 68.4 | 254.6 | 115.1 | 438.1 |

Visits(000's)/Average Daily Census

Total All

| Program Type | Pension | SC LT 50% | NSC Cat A | Total |
|---|---|---|---|---|
| VA Outpatient | 2232.9 | 5553.6 | 4247.7 | 12034.2 |
| VA Hospital | 109.5 | 407.6 | 184.2 | 701.3 |
| VA Nursing | 101.6 | 378.1 | 171.0 | 650.7 |
| Community Nursing | 68.4 | 254.6 | 115.1 | 438.1 |

Summary of the Estimated Cost for HR-1780

Millions of Dollars

Current Users

| Program Type | Pension | SC LT 50% | NSC Cat A | Total |
|---|---|---|---|---|
| VA Outpatient | 111.8 | 177.0 | 253.9 | 542.7 |
| VA Hospital | 0.0 | 0.0 | 0.0 | 0.0 |
| VA Nursing | 0.0 | 0.0 | 0.0 | 0.0 |
| Community Nursing | 0.0 | 0.0 | 0.0 | 0.0 |
| Total | 111.8 | 177.0 | 253.9 | 542.7 |

New Users

| Program Type | Pension | SC LT 50% | NSC Cat A | Total |
|---|---|---|---|---|
| VA Outpatient | 111.8 | 379.1 | 171.4 | 662.3 |
| VA Hospital | 12.9 | 48.1 | 21.8 | 82.8 |
| VA Nursing | 5.2 | 19.3 | 8.7 | 33.2 |
| Community Nursing | 2.0 | 7.3 | 3.3 | 12.6 |
| Total | 131.9 | 453.8 | 205.2 | 790.9 |

Total All

| Program Type | Pension | SC LT 50% | NSC Cat A | Total |
|---|---|---|---|---|
| VA Outpatient | 223.6 | 556.1 | 425.3 | 1205.0 |
| VA Hospital | 12.9 | 48.1 | 21.8 | 82.8 |
| VA Nursing | 5.2 | 19.3 | 8.7 | 33.2 |
| Community Nursing | 2.0 | 7.3 | 3.3 | 12.6 |
| Total | 243.7 | 630.8 | 459.1 | 1333.6 |

(Subquently, the Department of Veterans Affairs furnished the following information:)

A survey was conducted in the summer of 1988 to satisfy internal management interests about the nature and extent of the VAMC-sponsored outpatient activities. A list of Satellite Outpatient Clinics (SOC), Community-Based Clinics (CBC), Outreach Clinics (ORC) programs and Independent Clinics were reported in the "Survey of Outpatient Activities Held Away From VA Medical Centers," (Circular 10-88-69), conducted during the summer of 1988. The list includes all programs in operation and those planned for implementation within a year of the survey date. Since there has been a seven to eight months lapse in time since the survey was conducted, some changes in non-VAMC-based outpatient activities may have occurred, i.e., additions or deletions of programs, changes in plans. The list of outpatient clinics reported is as follows:

SATELLITE OUTPATIENT CLINICS

| CLINIC LOCATION | PARENT VAMC |
|---|---|
| 7th Ave, NY | New York |
| Mayaquez | San Juan |
| Ponce | San Juan |
| Lowell | Boston |
| Springfield | Northampton |
| Rochester | Batavia |
| Ryerson St. | Brooklyn |
| Newark | East Orange |
| Baltimore | Baltimore |
| Allentown | Wilkes Barre |
| Philadelphia | Philadelphia |
| Orlando | Tampa |
| Fort Meyers | Bay Pines |
| Oakland Park | Miami |
| Greenville | Columbia, SC |
| Pensacola | Biloxi |
| Jacksonville | Gainesville |
| Rivera Beach | Miami |
| Daytona Beach | Gainesville |
| Canton | Cleveland |
| Detroit | Allen Park |
| Crownpoint | Lakeside |
| Grand Rapids | Battle Creek |
| Toledo | Ann Arbor |
| Peoria | Danville |
| Evansville | Marion, IL |
| Portland | Portland |

SATELLITE OUTPATIENT CLINICS (Cont.)

| CLINIC LOCATION | PARENT VAMC |
|---|---|
| San Jose | Palo Alto |
| Sacramento | Martinez |
| Oakland | Martinez |
| San Diego | San Diego |
| Beaumont | Houston |
| Batton Rouge | New Orleans |
| Lubbock | Amarillo |
| Tulsa | Muskogee |

COMMUNITY-BASED CLINICS

| CLINIC LOCATION | PARENT VAMC |
|---|---|
| New Bedford | Providence |
| Buffalo | Buffalo |
| Springfield | Northampton |
| Worcester | Brooklyn |
| Northampton | Northampton |
| Albany | Albany |
| Springfield | Coatesville |
| Winston Salem | Salisbury |
| East Orange | East Orange |
| Philadelphia | Coatesville |
| Sayre | Wilkes Barre |
| Norfolk | Hampton |
| Harrisburg | Lebanon |
| Miami | Miami |
| Knoxville | Nashville |
| Port Richie | Tampa |
| Tampa | Tampa |
| Huntsville | Tuscaloosa |
| Florence | Tuscaloosa |
| Aniston | Tuscaloosa |
| Gadsden | Tuscaloosa |
| Decatur | Tuscaloosa |
| Key West | Miami |
| Chatanooga | Murfreesboro |
| Huntsville | Birmingham |
| Mobile | Biloxi |
| Miami | Miami |
| Columbus, GA | Tuskegee |
| Savannah, GA | Charleston, SC |
| Cleveland | Cleveland |
| Gaylord | Saginaw |
| La Junta | Fort Lyon |
| Billings | Miles City |
| Pocatello | Salt Lake City |
| Superior | Minneapolis |
| Colorado Springs | Denver |
| Berkley | Martinez |

COMMUNITY-BASED CLINICS (Cont.)

| CLINIC LOCATION | PARENT VAMC |
|---|---|
| Redding | Martinez |
| Eugene | Roseburg |
| Los Angeles | LA OPC |
| Santa Barbara | W. Los Angeles |
| Martinez | Martinez |
| Maui | Honolulu OPC |
| Napa City | San Francisco |
| Farmington | Albuquerque |
| Artesia | Albuquerque |
| San Antonio | San Antonio |
| Corpus Christi | San Antonio |
| Victoria | San Antonio |
| McAllen | San Antonio |
| San Antonio | San Antonio |
| Lawton | Oklahoma City |
| Odessa | Big Springs |

OUTREACH CLINICS/PROGRAMS

| CLINIC LOCATION | PARENT VAMC |
|---|---|
| Elizabethtown | Albany |
| Greenfield | Northampton |
| Pittsfield | Northampton |
| Lynbrook | Northport |
| Riverhead | " |
| Islip | " |
| Patchoque | " |
| Mt. Sinai | " |
| Lindenhurst | " |
| Hicksville | " |
| Sayville | " |
| Burlington | White River Junction |
| Montpelier | " |
| Rutland | " |
| St. Johnsbury | " |
| Newport | " |
| Keene, NH | " |
| Geneva | Canandaigua |
| Caribou | Togus |
| Watertown | Syracuse |
| Buffalo | Buffalo |
| White Plains | Montrose |
| Carmel | Montrose |
| Variable | West Haven |
| 5 county area | Canandaigua |
| Lyon | Canandaigua |
| White Plains | Montrose |
| Carmel | Montrose |
| Variable | West Haven |
| 5 county area | Canandaigua |
| Lyon | Canandaigua |

OUTREACH CLINICS/PROGRAMS (Cont.)

| CLINIC LOCATION | PARENT VAMC |
|---|---|
| White Plains | Bronx |
| Stuarts Draft | Salem |
| Pulaski | " |
| Lynchburg | " |
| Hillsville | " |
| Martinsville | " |
| Danville | " |
| Pottsville | Lebanon |
| So. Delaware | Wilmington |
| variable | Lebanon |
| Youngstown | Butler |
| Cambridge | Perry Point |
| Jamesburg | Lyons |
| Pittsburgh | Pittsburgh (HD) |
| Mobile | Biloxi |
| Jackson | Lexington |
| Cynthiana | " |
| Danville | " |
| Richmond | " |
| Frankfort | " |
| Irvine | " |
| London | Lexington |
| Maysville | " |
| Mt. Sterling | " |
| Paris | " |
| Versailles | " |
| Somerset | " |
| Morehead | " |
| Mobile | Biloxi |
| Decatur | Tuscaloosa |
| Cookeville | Murfreesboro |
| Laurelville | Chillicothe |
| Saginaw | Ann Arbor |
| Saginaw (Nuc Prog) | Ann Arbor |
| Kalamazoo | Battle Creek |
| Variable | Iron Mountain |
| Green Bay | Milwaukee |
| Grand Rapids | Battle Creek |
| Chicago | Chicago Westside |
| Grand Rapids | Battle Creek |
| Variable | Cleveland |
| Wellston | Chillicothe |
| Hammond | Chicago Westside |
| Athens | Chillicothe |
| Chicago Hghts | Chicago Westside |
| Portsmouth | Chillicothe |
| Springfield | Dayton |
| Pebbles | Chillicothe |
| Chicago | Chicago Westside |
| Napierville | Chicago Westside |

OUTREACH CLINICS/PROGRAMS (Cont.)

| CLINIC LOCATION | PARENT VAMC |
|---|---|
| Lancaster | Chillicothe |
| Springfield | Chicago Westside |
| Circleville | Chillicothe |
| LaCrosse | Tomah |
| Skokie | Chicago Westside |
| Toledo | Ann Arbor |
| Battle Creek | Battle Creek |
| Wash Courthouse | Chillicothe |
| Benton Harbor | Battle Creek |
| Lansing | Battle Creek |
| Rockford | North Chicago |
| Battle Creek | Ann Arbor |
| Newcastle | Hot Springs |
| Centerville | Knoxville |
| Billings | Fort Meade |
| Marshaltown | Knoxville |
| Albion | Grand Island |
| North Platt | Grand Island |
| Ord | " |
| Miles City | Fort Meade |
| Wilmar | St. Cloud |
| Rushville | Hot Springs |
| Fort Collins | Denver |
| Fort Morgan | Denver |
| Virginia | St. Cloud |
| Alexandria | St. Cloud |
| Sioux City | Sioux Falls |
| Houston | Poplar Bluff |
| Wolf Point | Miles City* |
| Marshaltown | Demoines |
| Cambridge | St. Cloud |
| Duluth | St. Cloud |
| Indianola | Knoxville |
| West Plains | Poplar Bluff |
| Paragould | " |
| Cherokee Village | " |
| Alliance | Hot Springs |
| Variable | St. Louis |
| Albia | Knoxville |
| Variable | Leavenworth |
| Holdridge | Grand Island |
| Richfield | Salt Lake City |
| Ottumwa | Knoxville |
| Torrington | Cheyenne |
| ELs. AFB | Hot Springs |
| Hibbing | St. Cloud |
| Roosevelt | Salt Lake City |
| Variable | Topeka |
| Cape Girardeau | Poplar Bluff |
| Mason City | Demoines |

OUTREACH CLINICS/PROGRAMS (Cont.)

| CLINIC LOCATION | PARENT VAMC |
|---|---|
| Bismark | Fargo |
| Nevada City | Reno |
| San Jose | San Francisco |
| Stockton | San Francisco |
| Fallon | Reno |
| Catchment area | Spokane |
| Santa Monica | West Los Angeles |
| Susanville | Reno |
| San Francisco | San Francisco |
| Yountville | " |
| Chico | " |
| Stockton | Livermore |
| Yerington | Reno |
| Owyhee, NV | Boise |
| Fairbanks | Anchorage |
| Yountville | San Francisco |
| Carson-Taho | Reno |
| Napa City | San Francisco |
| Hilo | Honolulu |
| Kona | " |
| Kauai | " |
| Variable | Fayetteville |
| Abilene/AFB | Big Springs |
| Clinton | Oklahoma City |
| Ardmore | Oklahoma City |
| Gallup | Albuquerque |
| Talahina | Muskogee |
| Tuba City | Albuquerque |
| Chinle | " |
| Ft. Defiance | " |
| Window Rock | " |
| Crownpoint | " |
| Shiprock | " |

INDEPENDENT CLINICS

Boston, MA

Columbus, OH

Las Vegas, NV

Los Angeles, CA

El Paso, TX

Anchorage, AK (RO/OPC)

Honolulu, HI (RO/OPC)

Manila, PI (RO/OPC)

The following is a summary of expenses of Satellite, Community-Based and Outreach Clinics, for FY 1987, as reported in the "1988 Survey of Outpatient Activities Held Away From VA Medical Centers," (Circular 10-88-69):

**REPORTED EXPENSES OF SATELLITE, COMMUNITY BASED, AND OUTREACH CLINICS, FY 1987**

| COSTS | SOC (N=32) | CBC (N=44) | ORC (N=108) |
|---|---|---|---|
| Direct Personal | $67,753,680 | $18,633,033 | $2,647,232 |
| Direct All Other | 38,096,177 | 10,867,543 | 506,451 |
| Indirect Personal | 12,536,002 | 3,042,205 | 285,473 |
| Indirect All Other | 4,224,185 | 1,711,930 | 225,246 |
| Lease - Space | 9,046,095 | 2,562,955 | 65,971 |
| Equipment | 57,929 | 493,203 | 66,425 |
| Other Costs | 37,572 | 19,636 | 31,935 |
| TOTAL | 131,751,641 | 37,330,505 | 3,828,733 |
| MEAN | 4,117,238 | 848,421 | 35,451 |

Cost data were reported for 184 outpatient programs (83%). To obtain an estimated cost for all outpatient activities held in areas away from VA Medical Centers, the average cost per SOC, per CBC, and per ORC were used as surrogates for the costs of those activities which were not reported. The revised totals, using this method of estimation, were as follows:

| | |
|---|---|
| SOC | $144,103,355 |
| CBC | 44,117,873 |
| ORC | 4,821,361 |
| GRAND TOTAL | $193,042,589 |

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TESTIONY OF THE AMERICAN PSYCHIATRIC ASSOCIATON

And The

NATIONAL ASSOCIATION OF VA CHIEFS OF PSYCHIATRY (NAVACOP)

BEFORE THE

HOUSE COMMITTEE ON VETERAN'S AFFAIRS

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

ON

DELIVERY OF PSYCHIATRIC SERVICES IN THE VA

PRESENTED BY

SPENCER FALCON, M.D.
PRESIDENT, NATIONAL ASSOCIATION OF VA CHIEFS OF PSYCHIATRY
CHIEF OF PSYCHIATRY, ANN ARBOR VA MEDICAL CENTER
ASSOCIATE CHIEF FOR ADULT SERVICES, UNIVERSITY OF MICHIGAN
DEPARTMENT OF PSYCHIATRY

APRIL 26, 1989

Mr. Chairman and Members of the Subcommittee, I am Spencer Falcon, M.D., President of the National Association of VA Chiefs of Psychiatry (NAVACOP). I am also Chief of Psychiatry at the Ann Arbor VA Medical Center, and Associate Chief of Adult Services, University of Michigan, Departmnt of Psychiatry. I am pleased to appear before the Subcommittee to represent the views and concerns of the American Psychiatric Association, a medical specialty society representing over 35,000 psychiatrists nationwide, and the specific concerns of NAVACOP. As always, we are encouraged by the support we receive from Chairman Montgomery and the Members of the House Veterans' Affairs Committee. Your dedication to providing quality health care to the men and women who have served this country is needed and commendable.

The mission of the Veterans Administration is one of diverse proportion, serving various needy veterans. However, it is important to recognize how essential the adequate provision of treatment for mental and substance abuse disorders is to the veteran population.

- In 1987, the VA provided 237,000 episodes of hospital care for psychiatric illness to 152,000 veterans. Ninety-three percent of all veterans discharged with a primary psychiatric diagnosis were either service-connected or eligible for inpatient care under Category A since their incomes are below $16,466.

- In 1983 alone, the VA provided 9.1% of all psychiatric inpatient care episodes in the nation and a 1980 NIMH patient sample survey estimated that 51% of all episodes of psychiatric hospitalization involving U.S. veterans occurred in the VA facilities.

In response to severe budget constraints, it is now, more than ever, critical that the VA reaffirm its mission to provide comprehensive psychiatric services to veteran patients. We can not permit the fiscal reality of no immediate prospect for substantial improvement to allow further erosion of VA Psychiatric services which have been traditionally chronically understaffed and underfunded.

Of unique importance to the VA mission — where 21 of the 24 neuropsychiatric hospitals across the country are located in rural settings — is the provision of psychiatric services by neuropsychiatric hospitals in rural health care settings. Large neuropsychiatric hospitals experience all of the problems and difficulties associated with health care in a rural setting, and more. These are hospitals with large numbers of psychiatric beds, and patients treated at these facilities suffer the most severe psychiatric illnesses, including schizophrenic disorders, psychotic disorders, major affective disorders and serious organic mental disorders. There is also an overrepresentation of alcohol abuse disorders in this population and a high comorbitity rate, including post-traumatic stress disorder with its multiple co-diagnoses. These patients require medically necessary care with complex inpatient treatment modalities and these facilities serve as their last resort for obtaining needed care.

If the VA cannot address the specific needs of these facilities, we will find the provision of medically necessary care to veterans suffering severe psychiatric disorders in grave jeopardy. If not treated successfully, these uninsured and/or service connected veterans will place a tremendous financial burden on the VA through high recidivism rates.

For example, as we look at the terrible toll and late sequela of substance abuse

within our veteran population, we recognize the need for strategic planning to direct resources into treatment of substance abuse conditions that will, in effect, prevent the need for extremely expensive, highly technical, tertiary treatment later. Specifically, the alcoholic patient who after years of untreated substance abuse may develop cirrhosis of the liver, pancreas, and other complications of alcoholism, or the veteran who uses I.V. substances, may subsequently develops AIDS, requiring extremely expensive treatment. We see in these instances the tremendous importance of psychiatric facilities if they can provide early treatment of these conditions, and through prevention of substantial morbidity and mortality which require greater medical care expenditures at a later point in the veteran's life.

For the most part, VA neuropsychiatric hospitals are completely isolated from affiliated medical centers, and therefore, all too often cannot gain assistance from the medical schools in recruitment efforts nor achieve the continuing education important to provide quality care. In addition, because they are large and serve a complex and severely ill population, they are expected to deliver specialty and subspecialty care. Working conditions are difficult and the treatment required is intensive. Patient to staff ratios are too high and staff vacancy rates continue to climb. In addition, many of the problems associated with staffing, recruitment, and quality of care issues in these rural hospitals, to some extent a reflection of their geographic isolation, are compounded by the unfortunate fact that these rural facilities have become in many respects the final referral site for many of the psychiatric and substance abuse problems associated with our veteran population.

Delivery of care is further complicated by the practice of transferring patients with psychiatric and substance abuse conditions from other VA psychiatric

facilities and from small-unaffiliated VA hospitals with no psychiatric beds, to these facilities for longer term and more intensive treatment. This is particularly true if the patients are difficult patients with high levels of recidivism or if the patients have shown failure to respond to treatment in a shorter term setting. Therefore, by design, perhaps unwittingly, the Veterans Administration has positioned these hospitals in geographically isolated locations that today are causing substantial difficulties in the ability to maintain high quality staff and to deliver quality care in these settings.

The VA, medical schools and affiliated hospitals' awareness levels must be raised to address the problems experienced at neuropsychiatric hospitals. If any progress is to be made, efforts should be undertaken to establish shared educational programs, to assist with recruitment of specialty medical professionals, and to form closer ties with rural facilities .

The quality of care for all psychiatric patients is being compromised by the VA's documented inability to recruit and retain qualified health care personnel. Clearly, the impact of high staff vacancy rates on delivery of mental health care in the VA is significant, and their inability to attract qualified psychiatrists, nurses and other health care professionals is further amplified in rural areas. Almost no one anticipates the need for services to diminish, and thus, the situation can only worsen.

Let me share with you the last four years' experience with VA psychiatric patient workload. Since the implementation of the Resource Allocation Methodology (RAM) — the VA equivalent of hospital DRGs (Diagnosis Related Groupings) which Medicare did <u>not</u> apply to psychiatric hospitals or psychiatric units of general hospitals because the research data did <u>not</u> support psychiatric DRGs — VA

Psychiatry has experienced a 21% increase in episodes of care, and a 13% increase in the number of unique individuals treated. By 1987, the percentage of discharges for individuals suffering dual diagnosis conditions involving a serious psychiatric disorder and an alcohol or substance abuse disorder exceeded 74%. Yet, despite the increased census, and an evidenced need for more complex treatment with a higher level of care, the proportion of VA funds distributed to psychiatry bed sections has declined.

The RAM model provides incentives for markedly shortening the length of stay and for developing outpatient treatment and alternative delivery settings. Psychiatry supports the concept that more patients should as appropriate be treated in an alternative setting. One must recognize that there are still large numbers of patients who must receive inpatient treatment due to the nature of their illnesses. VA psychiatry has responded to the demands of the RAM model with a 34% decrease in length of stay (from 47 days to 31 days). This occurred between 1984-1987. However, during that time, there has been a 20% decrease in dollars spent per episode of care. Since there has never been an increase in funding, the effect of RAM implementation upon delivery of psychiatry services in the VA has been to increase outpatient care at the expense of ignoring the inpatient treatment facilities.

The patient population in neuropsychiatric hospitals responds poorly to short-term treatment, experiencing a significant increase in readmission within 14 days — which reaffirms the validity of the noted Congressional Medicare decision to exempt psychiatry from the Medicare DRG prospective payment system. Neuropsychiatric hospitals, with their long term psychiatric patients receiving inappropriate attention and recognition under the reimbursement system, are consequently not equipped with the staffing and resources to deal with the

dramatic increase in number of admissions. Therefore, there has been a steady erosion in their ability to maintain quality psychiatric and substance abuse programming.

With the support of the VA Associate Deputy Chief Medical Director, the Mental Health & Behavioral Sciences Service recently conducted a field study in response to concerns over the increasing number of psychiatric physician vacancies and difficulties in the retention of psychiatrists. There are currently 1860.63 total psychiatric physician full-time employee equivalents (FTEEs). The survey of 160 VA Medical Centers documents a 14.59% vacancy rate for all psychiatric physicians. There are 269 FTEE vacancies, of which 29 are full-time Chief of Psychiatry vacancies, 189 are full-time staff vacancies and 50 are part-time staff vacancies.

VA Neuropsychiatric hospitals experience vacancy rates are in excess of the already high total. The vacancy rate for psychiatrists located in centers with large psychiatry bed sections is 16.4%. Eighteen percent of psychiatrist vacancies have been vacant six months or less, more than 70% of the psychiatry vacancies have been vacant seven months or more, and 13% of psychiatrist vacancies have a duration of 13 months or more. The total vacancy rate for unaffiliated medical centers is 24%, with 33% having a duration of 1-6 months, 66% with a duration of 7 months or more, and 13.5% have been open for 13 months. In contrast, the vacancy rate for affiliated VAMCs, usually located in urban settings with smaller psychiatric bed sections, is 11.6%.

The study concluded that unaffiliated VAMCs and those with large psychiatry bed sections, predominately located in rural settings, have greater recruitment and retention problems in psychiatry. VAMCs located in rural areas are unable to

obtain the necessary mix of fully credentialed board certified psychiatrists and other staff, or compete with private and state facilities for these professionals. The results are particularly alarming when one considers that an April 1988 White Paper estimated that, of the total number of psychiatrists predicted to retire from the VA by 1990, 42.7% will come from hospitals with large psychiatric bed sections.

The VA study cites, as major obstacles to recruitment and retention efforts, the attractiveness of competing salaries and fringe benefit packages. State facilities, which have experienced many of the same recruitment and retention difficulties, have responded to their crises by substantially increasing starting salaries. The VA now faces stiff competition with state salary levels as well as with the attractiveness of private practice. Competing employers offer the potential for private practice, better fringe benefit packages and lighter work loads.

For example, in Indiana, Logansport State Hospital advertises a starting salary for a staff psychiatrist of $102,830. In Michigan, my home State, State facilities offer starting salaries of up to $97,000 for a 40 hour workweek, and an "on-call differential" in addition to this. In comparison the average starting salary for a VA board-certified psychiatrist is $75,000-$80,000.

We support the report's recommendations which call for salary increases for psychiatrists through the granting of scarce specialty status for psychiatry, allowing for renumerated outside activities, enhanced research opportunities, improved working conditions and reduced workloads. It is our understanding that these recommendations have been submitted for review to the Chief Medical Director's Field Advisory Group and the Quadrennial Commission on Physician Pay.

We urge your strong support for timely implemenation of an action plan based on this report's recommendations.

We are concerned that as psychiatrists who are staffing neuropsychiatric hospitals continue to be more isolated from mainstream state-of-the-art psychiatric development, many hospitals will accept alternatives to psychiatric physicians care.

We are all aware of the impact VA budget constraints have had, and continue to have, upon delivery of medical services to veterans across the country. It is now clear that stigma will occur with a vengeance, and a disproportionate share of the impact is being felt by the most vulnerable of the VA population. These include those who are uninsured, service connected, and suffering from the most debilitating of mental illnesses, such as schizophrenic disorders, psychotic disorders and serious organic mental disorders.

Critical alcohol and drug treatment services and research programs have been eliminated, the number of closed beds continues to escalate and homeless veterans remain on the streets. If steps are not taken to ensure delivery of psychiatric care in the VA medical system, health care delivery systems across the country, especially those in rural settings, will be faced with even greater influxes of patients suffering from psychiatric illnesses. State facilities are already at maximum capacity, struggling to cope with their own budget constraints. Those state mental health systems who have cooperated with the VA in an attempt to address the expanding need for services, cannot absorb any more of the burden.

These veterans have no options and the Veterans Administration must address their needs.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
April 26, 1989

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.2 million members of the Disabled American Veterans and its Ladies' Auxiliary, I am pleased to have the opportunity to appear here today and present our views on legislation relating to the Department of Veterans Affairs' (DVA) health care system.

Mr. Chairman, your letter of invitation requested our views regarding H.R. 1780, a bill to revise eligibility for outpatient medical services; H.R. 1931, the "Childless Veterans Assistance Act of 1989;" as well as comparison of the costs of providing DVA and non-DVA health care; and the effects of budgetary constraints and current resource allocation methods on the provision of DVA health care to veterans in rural areas.

While we certainly appreciate the opportunity to provide testimony regarding H.R. 1780 and H.R. 1931, we are unable, at this time, to include detailed testimony regarding the remaining issues of immediate interest to the Subcommittee. However, because of their important nature and our interest in these areas, we request the record remain open for a reasonable amount of time to allow us to address these two remaining issues.

H.R. 1780

Introduced by a distinguished member of this Subcommittee, Mr. Jontz, H.R. 1780 proposes to amend Section 612(a), Title 38, USC, thereby bringing into conformity eligibility for the provision of outpatient services to that which is stipulated by law for providing inpatient care, to a certain, defined universe of veterans.

Simply stated, this measure would, if enacted, mandate DVA to provide outpatient medical services to those veterans eligible for hospital care under the provisions of Section 610(a)(1), Title 38, USC -- "Category A" veterans.

As you know, Mr. Chairman, "Category A" veterans are specifically defined as:

* veterans seeking care for a service-connected disability;

* veterans whose discharge or release from the active military service was for a disability incurred or aggravated in the line of duty;

* veterans disabled as a result of DVA medical treatment or vocational rehabilitation (Section 351, Title 38, USC);

* veterans rated 50% or more for service-connected disability(ies);

* veterans who have a service-connected disability;

* veterans who are former prisoners-of-war;

* veterans exposed to certain herbicides (Agent Orange) or Ionizing Radiation;

* veterans of the Spanish American War, Mexican Border Period or World War I; and

* nonservice-connected veterans who are determined unable to defray the expenses of necessary medical care.

During the 100th Congress, this Subcommittee, under your stewardship, Mr. Chairman, took to the forefront the issue of eligibility and entitlement of veterans to receive DVA provided outpatient services.

As a result of those efforts, P.L. 100-322 was enacted on May 20, 1988. Pertinent provisions of P.L. 100-322 revised the eligibility criteria for veterans to receive outpatient medical services, stipulating DVA shall furnish such services as are determined necessary to:

* a veteran for a service-connected disability;

* a veteran for any disability, who has a service-connected disability rated at 50% or more; and

* a veteran -- determined eligible to receive benefits -- for a disability under the provisions of Section 351, Title 38, USC.

Additionally, DVA is mandated to provide outpatient medical services which are reasonably necessary in preparation for hospital admission or to obviate the need of hospital admission to:

* a veteran having a service-connected disability rated at 30% or 40%; and

* a veteran eligible for inpatient care under Section 610(a), Title 38, USC, whose annual income does not exceed the maximum annual rate of pension that would be applicable if the veteran was determined eligible for pension.

Finally, P.L. 100-322 stipulates DVA may furnish outpatient medical services to:

* a veteran who is a former prisoner-of-war;

* a veteran of the Mexican Border Period or of World War I; and

* a veteran eligible for increased pension or compensation based on the finding of need for regular aid and attendance or by reason of being permanently housebound.

Mr. Chairman, in our view, the very same logic employed in enacting P.L. 99-272, "The Consolidated Omnibus Budget Reconciliation Act of 1985," mandating DVA to provide inpatient hospital care to a specifically defined category of veterans, holds true when one considers the need to be furnished outpatient medical care.

Mandated entitlement and access to inpatient hospital care does not always meet the veteran's true medical needs. Often, the veteran may only require the less costly mode of outpatient

care to stabilize and/or monitor medical conditions for which hospitalization is unnecessary, but may occur if the condition is left to deteriorate.

Certainly, this is not sound medical or fiscal management.

In our view, H.R. 1780 will substantially improve veterans' access to needed outpatient care and prove medically beneficial. Therefore, this bill has the full support of the DAV.

H.R. 1931

Introduced by Mr. Kennedy, a distinguished member of this Subcommittee, H.R. 1931, the "Childless Veterans Assistance Act of 1989," would, via amending Section 612, Title 38, USC, add a new subsection authorizing the Secretary, at his discretion, to:

* provide to an eligible veteran (and, if necessary, the veteran's spouse) qualifying procreative services; and

* reimburse a veteran for certain expenses incurred in the adoption of a child, the amount of which may not exceed $2,000.

Mr. Chairman, the DAV has no official position relating to H.R. 1931 or the perceived intent of this measure: to permit veterans who are unable, due to service-connected causes, to otherwise biologically conceive a child, to receive assistance (to the reasonable extent necessary) to overcome the effects of their disability.

The DAV has previously testified on proposed legislation similar in nature to the provisions of H.R. 1931. As we have in the past, we feel it necessary to set forth our concerns regarding this issue.

Initially, we applaud Mr. Kennedy for his interest and commitment in pursing a legislative remedy that would permit a veteran who is unable, solely as a result of service-connected disability, to become a proud mother or father. (It is indeed unfortunate that DVA continues to hold to the belief -- mistakenly, in our view -- that they lack authority to provide these services under current law.)

With respect to H.R. 1931, as in past proposals of a similar nature, we agree with the basic intent. Certainly, it is a natural, driving desire of most individuals to have the ability to procreate and produce a natural, biological child. Obviously, in the case of some, including veterans, that may not be possible due to the presence of various diseases or disability. When such conditions are present there are alternatives available, albeit some controversial and others continuing to evolve.

Mr. Chairman, we are mindful of and support the language of this measure limiting, under current medical knowledge, what methods of achieving pregnancy are considered to be authorized to be provided as reasonable and necessary to overcome the effects of a veteran's service-connected disability. However, we continue to be concerned and feel specific language should be set forth expressing limitations of any measure that may be favorably reported by the Subcommittee.

Our interpretation of the proposed new Subsection (k)(1)(A) is that services would be provided to achieve pregnancy. Therefore, we do not envision DVA to be required to provide obstetric services, pre-natal or post-natal care in conjunction

with any successfully achieved pregnancy. We would also raise the issue of the Department's potential liability relating to possible complications and/or permanent disability to the mother or possible birth defects affecting the child.

Similarly, the issue of adoption raises, in our mind, the same spectrum of questions. This is especially true when all of us know and are so very much aware of the current budget shortfall and constraints facing DVA today and, perhaps, into the foreseeable future.

The issue then becomes how much DVA is required to do and what limits they have in carrying out their stated mission of providing quality and timely health care services to this nation's disabled veterans.

Mr. Chairman, as always, we are certainly willing and eager to work with the Subcommittee in discussing these and other issues that directly influence the health care services available to disabled veterans from the Department of Veterans Affairs.

That concludes my testimony and I would be happy to respond to any questions you may have.

# VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

ROBERT D. MANIAN, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

ELIGIBILITY FOR DVA HEALTH CARE AND OTHER HEALTH CARE ISSUES

WASHINGTON, D. C. APRIL 26, 1989

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.9 million members of the Veterans of Foreign Wars of the United States and its Ladies Auxiliary, I wish to sincerely thank you for having included the VFW in today's hearing addressing veteran's health care issues. As you know, the provision of first-rate health care to this nation's veterans through the Department of Veterans Affairs health-care system is one of our organization's primary concerns. Thus, we are both pleased and proud to take part in today's discussion.

First under consideration today is H.R. 1780, legislation introduced by Congressman Jontz of this Subcommittee, to revise eligibility for VA outpatient care. More specifically, this bill would bring the eligibility criteria outlined under section 612(a) of title 38 USC into conformance with those of section 610(a) of title 38 USC. In concurrence with current VFW Resolution Number 605 entitled "Entitlement to VA Outpatient Care," which resolves that "all veterans classified as category 'A' be entitled to outpatient treatment by the Veterans Administration," we support this

legislative proposal and we thank Mr. Jontz for its introduction.

Next under consideration today is draft legislation to assist service-connected disabled veterans who are childless. This draft legislation entitled "Childless Veterans' Assistance Act of 1989" provides for procreative assistance and adoption assistance for certain married veterans with service-connected disabilities. This legislation provides that the Secretary may provide to an eligible veteran, and if necessay the veteran's spouse, qualifying procreative services. By procreative services it is meant those that are reasonable and necessary to overcome the effects of a service-connected disability to a veteran who has such a disability which prevents or impairs the ability of the veteran and the veteran's spouse to conceive a child.

In this regard, it is a matter of record that the VFW strongly supported similar legislation which was introduced in the last Congress. It is our strongly held conviction that service disabled veterans comprise a very special segment of the veteran population and that they are due very special treatment by the Federal Government in order to overcome and better live with their varying disabilities. Certainly, the inability to conceive a child is a source of great pain and distress to anyone so afflicted, and any individual who is so disabled through service in the Armed Forces should not be denied the joy of rearing his or her own children if it can be helped. Once again, the VFW strongly supports this legislative proposal.

Similarly, the VFW supports the section of this legislative proposal which would reimburse a veteran for qualifying adoption expenses. This can only be viewed as a wise and compassionate initiative both for the concerned

veteran and his or her spouse and, of course, the adoptive child. The veteran is afforded the means whereby he may bring a son or daughter into his home and the child is given a loving home and caring environment where he may have otherwised remained in an institutionalized setting until reaching adult years. This measure enjoys VFW support.

Next under consideration today is a comparison of VA vs. non-VA health care with respect to the relative cost. In this regard, I should first articulate the VFW's fundamental concern that veterans be provided with the very highest level of health care possible. We are, of course, acutely aware of and attentive to the dictates of fiscal responsibility during this period of budgetary austerity. Even so, we maintain what this nation's veterans have earned and deserve the best in health care that this nation has to offer. However, having said this, we are pleased to point to the fact that the VA health-care system is, in fact, the most cost-effective means of providing health care in existence today.

Along with making tremendous contributions to the well-being of the general American public through its scientific and medical endeavors this integated health-care system, through operation of what may be termed the medical "economy of scale," is now providing the most amount of health care for the least amount of dollars. Thus, the Veterans of Foreign Wars firmly supports the continued operation and maintainence of the DAVA health-care system as this nation's primary provider and guarantor of health care to veterans. In current VFW Resolution Number 651, entitled "Adequate Funding for VA Hospital and Nursing Home Beds," the VFW asks that "the Veterans Administration be required primarily to use all of the available beds in the

system needed for the health care of veterans before utilizing any private sector facilities for similar services and that adequate funding be provided to care for an ever-increasing number of aging veterans."

The last item under discussion today is the effect of current resource allocation methods on the provision VA health care in rural areas. This is a problem area. Rural hospitals are, for the most part, small and unaffiliated hospitals which do not get the same consideration as do the VA's larger medical centers. For one thing, the fact that they are not affiliated with medical schools means that they are not allocated as much funding as some of the larger hospitals. So they start out at somewhat of a disadvantage. Then, of course, there is the fact that the medical "economy of scale" works to their disadvantage. Simply stated, on a per capita basis, it is less expensive to treat, say, 5,000 patients than it is to treat only 1,000. However, even though the per patient costs to rural hospitals is generally higher than in larger urban settings, current resource allocation methods do not make an adjustment for this difference. Another problem with the small rural hospitals is that it is much more difficult to attract top notch health-care specialists than for the larger VAMCs. The reason for this is physicians and other health care providers tend to be attracted to larger urban areas because of their social cultural and educational advantages. Additionally, rural VAMCs, for the most part, do not provide the same level of professional and scientific exposure as do large urban VA medical centers with their strong affiliations with universities and university medical schools. Although it would seem unlikely that any resource allocation methodology could fully accommodate these differences and level the playing field between the small

rural hospitals and their large urban counter parts, it would seem that they should take the increased cost of both providing health care to veterans and of attracting medical professionals into consideration.

Mr. Chairman, once again I thank you and this distinguished Subcommittee for having asked for the VFW's participation in this important hearing. While providing health care to this nation's veterans, the VA health-care system is also making invaluable contributions to American society in general. It certainly warrants our most careful and most considered attention. Germane VFW resolutions are appendant to this testimony for your review and I will be happy to respond to any questions that you may have.

Resolution No. 605

ENTITLEMENT TO VA OUTPATIENT CARE

WHEREAS, a sound medical program emphasizing preventive care is best accomplished by access to outpatient treatment; and

WHEREAS, certain Category "A" veterans are entitled to outpatient care under the means test; and

WHEREAS, the majority of nonservice connected veterans are entitled only to inpatient care, and, therefore, can be expected to delay seeking help until a condition deteriorates to a potentially life threatening level requiring inpatient care; and

WHEREAS, those nonservice connected veterans classified as Category "A" are the most needy of the veteran population; now, therefore

BE IT RESOLVED, by the 89th National Convention of the Veterans of Foreign Wars of the United States, that all veterans classified as Category "A" be entitled to outpatient treatment by the Veterans Administration.

Adopted by the 89th National Convention of the Veterans of Foreign Wars of the United States, held in Chicago, Illinois, August 19-26, 1988.

Resolution No. 605

Resolution No. 651

ADEQUATE FUNDING FOR VA HOSPITAL AND NURSING HOME BEDS

WHEREAS, the Grace Commission has recommended closing the entire Veterans Administration system and that veterans and welfare recipients alike should obtain health care in private hospitals and nursing homes; and

WHEREAS, the Veterans Administration has been directed by government officials to place greater reliance on state and local community nursing home facilities to meet the requirements of veterans for nursing home care; and

WHEREAS, since the Gramm-Rudman-Hollings balanced budget law mandated cuts for virtually all VA programs and services, subsequent plans for a number of new VA nursing homes were abandoned, and many others are under consideration for closure; and

WHEREAS, the Veterans Administration today is operating well below the 90,000 total hospital beds required by law, with the Administration's proposed fiscal year 1989 budget calling for a further decline in bed levels available for veterans with health care problems; now, therefore

BE IT RESOLVED, by the 89th National Convention of the Veterans of Foreign Wars of the United States, that the Veterans Administration be required primarily to use all the available beds in the system needed for the health care of veterans before utilizing any private sector facilities for similar services, and that adequate funding be provided to care for an ever increasing number of aging veterans.

Adopted by the 89th National Convention of the Veterans of Foreign Wars of the United States, held in Chicago, Illinois, August 19-26, 1988.

Resolution No. 651

STATEMENT OF
JOHN C. BOLLINGER
ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
H.R. 1780 TO REVISE ELIGIBILITY FOR DVA OUTPATIENT CARE,
THE "CHILDLESS VETERANS ASSISTANCE ACT OF 1989," COST COMPARISON
OF DVA AND NON-DVA HEALTH CARE AND
THE PROVISION OF DVA CARE IN RURAL AREAS
APRIL 26, 1989

Mr. Chairman and Members of the Subcommittee, on behalf of the members of Paralyzed Veterans of America [PVA], I wish to thank you for this opportunity to present our views on these very important issues. Access to quality health care is of critical importance to PVA's members and all veterans. The issues of infertility and adoption, as well have a very special significance for many of our members. The issues of cost effectiveness of Department of Veterans Affairs [DVA] health care and the availability of care for veterans in rural areas are particularly important as the government is facing difficult budget decisions regarding funding allocations for all aspects of federal health care.

Mr. Chairman, PVA has continuously advocated for the expansion of outpatient eligibility for Category "A" veterans since the enactment of Public Law 99-272. We deeply appreciate the efforts of this Subcommittee and applaud the introduction of H.R. 1780 by Representative Jontz. The need for this legislation is evident for several reasons, none more important, though, than it assures many veterans access to health care who have neither the necessary private resources or eligibility in other federal health care programs to receive needed care.

Beginning with the first "Independent Budget," PVA joined with the AMVETS, Disabled American Veterans and the Veterans of Foreign Wars in encouraging the expansion of eligibility for outpatient care for all Category "A" veterans. This proposal was predicated on several factors including enhanced access to care, increased flexibility in applying improved and cost-effective modalities of care and managerial improvements.

Expanding the eligibility to outpatient care for all Category "A" veterans is consistent with the trend in modern medicine to develop alternatives to inpatient sources of care. By enhancing access to other than inpatient care the expansion of eligibility for outpatient services will contribute to moving the DVA health care system toward enhanced treatment modalities that are both more economical and do more to foster the independence of the veteran patient. Following ackowledged national health care trends, The DVA system has been moving to more use of non-institutional care The Department has expanded both outpatient acute care and a variety of non-institutional long-term care modalities. But certainly, more can and should be done in both these areas, but particularly in outpatient services which have proven to be the most cost-effective means to facilitate the distribution of health care services. The DVA has been a leader in operating a vertically-integrated healthcare system and should continue that leadership by adjusting the balance of care modalities to the changing needs of its patient population and to changes in healthcare techniques. Enactment of H.R. 1780 will greatly facilitate this effort.

H. R. 1780 expands outpatient eligibility to those Category "A" veterans who currently can only receive outpatient care "to obviate the need" for

inpatient services. Since the enactment of Public Law 99-272 there has been considerable latitude in the exercise of physician's judgment regarding the interpretation of "to obviate the need" for hospitalization. The marked reductions in DVA inpatient census and length of stay are primarily dollar driven, stemming from the imposition of DRG-based resource distribution and decremental budgets. Similarly, it appears that outpatient care to obviate the need for hospital admission is now more restrictively and arbitrarily granted.

Particularly for the chronically ill, medically indigent veteran with no service-connected disability, this is most unfortunate. Such a patient may have need of ongoing close medical supervision only to be told that hospitalization is not necessary and therefore DVA-furnished outpatient care is not available. He is likely to have no other means of access to care unless he also qualifies for Medicaid. The Medicaid patient, incidentally, is provided ambulatory care regardless of inpatient care need -- an arrangement certainly more cost effective than inviting, through patient neglect, a crisis need for hospitalization. However, Medicaid is not an alternative for most indigent veterans under 65 because they do not meet its categorical eligibility requirements. If they are unable to enter the DVA system for diagnostic and therapeutic outpatient services, these veterans are more than likely to return later due to an emergent condition requiring expensive inpatient care. Or, they will add to the uncompensated care burden that private sector providers are increasingly shunning or fail entirely to obtain care when it is needed.

The DVA healthcare system has always been distinguished for its offering certain patients a comprehensive, coordinated continuum of care. It is regrettable that PL 99-272 did not endorse that concept in the course of realignment of entitlement for all Category "A" veterans. Unrestricted outpatient care for all Category "A" veterans would not only make for a better quality of care, simplify administrative management, encourage preventive care, reduce the incidence of acute complications, and -- in the last analysis --better serve cost containment. Indeed, the Congressional Budget Office, in the analysis of the original version of PL 99-272 which included full outpatient entitlement, judged it to be a cost saving legislative proposal.

The enactment of H. R. 1780 would provide additional consistency of service to veteran patient as modalities of treatment evolve and the shift from inpatient to outpatient procedures continues. For example, a veteran who may have had a cataract removed on an inpatient basis when that procedure required hospitalization now cannot have a second cataract removed due to the procedure now being performed on an outpatient basis.

The expansion of eligibility for outpatient care for all Category "A" will help to preclude continuing misunderstanding by veteran patients and, DVA health care personel themselves regarding the distinctions between eligibility and entitlement. Administrative procedures, too, will be simplified resulting in improved efficiencies and enhanced planning data. The establishment of a more clearly defined eligibility can lead to a better depiction of veteran need and the anticipated healthcare system workload. With the development of such information resources and facilities requirements can be more accurately forecasted and provided. The ultimate result will be enhanced medical care and improved allocation and utilization of resources.

## "CHILDLESS VETERANS ASSISTANCE ACT OF 1989"

Mr. Chairman, on behalf of the members of Paralyzed Veterans of America, we deeply appreciate the Subcommittee addressing this issue of assistance to veterans who are unable to have children due to a service related disability. PVA particularly wants to thank Representative Joe Kennedy and his staff for the introduction of this legislative proposal which will serve to enhance the quality of life for certain PVA members and other veterans.

PVA has testified before this Subcommittee and other Committees in Congress over the past several years advocating for the need for legislation authorizing the Department of Veterans Affairs to provided procreative assistance to eligible veterans. As you are undoubtedly aware, PVA has been in the forefront for a number of years in sponsoring research and attempting to increase awareness of procreative disabilities. A disability which is particularly painful since it is one that may involve the veteran's inability to have children. It is also a disability which, for too long now, has gone

virtually unnoticed except, of course, by those individuals who, as a direct result of service to their country, or due to other medical conditions, will never be able to parent children, unless certain essential medical services can be provided.

PVA has, since its formation over forty years ago, been a strong and determined advocate for expansion of the roles for disabled individuals. We have worked persistently to promote improvements in the quality of life for all people with handicaps. We have come a long way when one considers that most veterans returning home with spinal cord injuries after World War II faced a life expectancy from 6 months to no more than five years. Today, the life expectancy following most spinal cord injuries is comparable to the rest of the population if the individual survives the initial 6 months after injury.

Thanks to the support we have received in Congress, the Department of Veterans Affairs and the private sector, not only are these veterans living longer, they are living at home in an accessible environment; sixty-five percent are driving specially-adapted vehicles; they are enrolled in vocational rehabilitation and education programs; they are becoming successful lawyers, architects, teachers and even Members of Congress. But there is one area that society, including the DVA, has overlooked. There is one disability the federal government and the DVA are not helping to overcome. As a result, some of these veterans may never know the fulfillment of becoming parents. To PVA, whose mission it is to encourage these veterans "to know no boundaries," this is a serious shortcoming.

Up until a few years ago, most spinal cord injured males were told two things: first, you will never walk again; second, you will never have children. Today, thanks to advanced and accepted medical technology for many spinal cord injured veterans, the latter just does not have to be true any more. The "Childless Veterans Assistance Act of 1989" goes a long way in ensuring that these veterans will receive the necessary support and assistance to overcome this disability.

It seems unconscionable that the DVA will provide a veteran compensation for the loss or loss of use of one or more creative organs under Section 314[K] of title 38 U.S. code, but will not afford the same veteran access to medical care to mitigate the resultant condition or provide financial assistance in the case of adoption. If this approach was applied in all cases, the overall health care and assistance provided to veterans would be extremely limited and new medical procedures and benefits would seemingly never be applied. Examples are too numerous to list.

Mr. Chairman, this legislation not only affords certain eligible veterans access to medical procedures which can assist in overcoming this disability, it also provides support for veterans whose only option is to adopt children. The provision of this additional benefit to childless veterans is both necessary and appropriate. For certain married couples, adoption is the only recourse to establishing a family and the costs associated with adoption have risen dramatically during recent years.

PVA certainly supports this legislation as a necessary step in providing total rehabilitation to service-connected disabled veterans. PVA recognizes that this legislation is a beginning and that all available technologies are not provided, most notably invitro fertilization. While these viable and medically tested options are excluded in the legislation it never-the-less offers many veterans the opportunity to enhance their overall quality of life.

Cost Comparison of DVA and NON-DVA Health Care

Mr. Chairman, PVA is convinced that the DVA health care system delivers the most cost effective medical treatment in the United States. How else could the Nation's largest health care system survive over the past decade at a time of soaring health care costs, skyrocketing demand for services and virtually straightlined budgets in terms of the medical inflation rate over that same period?

The current funding shortfall, as we have testified many times previously, is, indeed, presenting an unprecedented crisis for the DVA. But at the same time, funding restrictions absorbed over past years by the Department have forced its health care system to become more efficient and basically more careful in how those scarce resources are allocated. We do not believe this trend can continue any longer without seriously endangering the viability and

the quality of health care services. But, for the purposes of this discussion, a strong argument supporting the cost effectiveness of DVA health care versus other private and public health programs is clear just by looking at overall federal health budget allocations in recent years.

PVA recently published an analysis of federal health spending entitled "The Federal Health Budget and Health Care For Veterans - Fiscal Year 1990." This review was written by PVA Senior Medical Advisor, Dr. Donald L. Custis, M.D. and PVA medical consultant Frank Marrone. With your permission, Mr, Chairman, I request that this document be placed in the hearing record.

According to this report, the average annual percent of increase for all federal health programs from 1985 through 1990 (estimated) was 9.37 percent. During that period:

Medicare spending rose 8.84 percent.
Medicaid spending rose 13.21 percent.
Even the Department of Defense health care allocation rose 9.52 percent.
At the same time, and during the same period, increases in DVA health care spending rose only 3.70 percent.

It appears from these figures and from all other reports that the DVA is in serious financial difficulty. But these same numbers and trends prove that over the past five to ten years the Department has learned to do more with less, to be more efficient and certainly less profligate than its counterparts in other private and public health care systems.

Dropping down from this macro form of analysis to a systematic micro review of individual medical centers or even a comparison of specific episodes of treatment within and without the DVA has become somewhat problematical. While there is certainly ample anecdotal evidence to prove that VA health care is cheaper - most recently, the January 4, 1989, Department of Defense memorandum on VA - DOD sharing agreements sent to the Chairman of the House Appropriations Committee, Rep. Jamie L. Whitten, by Assistant Secretary of Defense For Health Affairs, William Mayer, M.D. - there still has been no systematic effort undertaken to arrive at an overall statistically significant and reliable measure of the cost of DVA care versus other health programs or providers.

Based on our contacts with DVA medical centers on this subject, the fault for this lack of information does not rest with the VA, where individual budget figures are clearly identifiable, but in the inability to obtain accurate and readily comparable financial information from other health care systems or affiliated hospitals in the private sector.

PVA believes that the DVA health care system can serve as a model of health care delivery for the Nation. This is so, particularly at a time when the cost of health care, the availability of health care, and even the quality of health care services varies so greatly from community to community across the country. For this reason, in making a case for the DVA system, we believe that the time has come to undertake a major study of DVA costs and other public and private health care expenses in order to be able to state once and for all: "the DVA system is the best health care bargain in the Nation."

## PROVISION OF DVA CARE IN RURAL AREAS

Mr. Chairman, you have also asked us to addressed the effects of budgetary constraints and current resource allocation methods on the provision of DVA care in rural areas. It must be stated at the outset that, for PVA's members, health care in most rural settings is not a viable option whether it is provided by the Department of Veterans Affairs or other medical entities. The special multimodal care required by individuals with spinal cord injuries have historically been found in large urban environments. The one aspect of DVA medical programs that has proved effective for many of our members has been beneficiary travel which has afforded them access to these urban health care settings. Erosion of the beneficiary travel program would not only impose a financial burden on these rural veterans but potentially foreclose access to health care when it is most needed. For PVA's members who are not entitled to beneficiary travel access to care is almost always a matter of emergent conditions and the recourse to family, neighbors or friends for transportation.

Rural health care for the entire veteran population must be viewed in the context of general rural health care which is faced with a crisis situation. DVA's role must be an integrated part of a larger federal health care initiative which addresses the problems of hospital closures, under staffing of remaining health care entities and the dwindling number of both general and specialty medical care providers. Where the Department does operate facilities in rural settings they often serve a broader medical purpose than just providing care to veterans. These DVA facilities are frequently the one source attracting physicians and other health care professionals to the area.

Mr. Chairman and Members of the Subcommittee, on behalf of the members of PVA, thank you for conducting this hearing and addressing these issues of concern to our nation's veterans. This concludes my statement and I will try to answer any questions you may have.

# THE FEDERAL HEALTH BUDGET AND HEALTH CARE FOR VETERANS--FISCAL YEAR 1990

## INTRODUCTION

This paper is an update of an article with the same title that appeared in the January 1989 issue of Paraplegia News. Much of the new information included has its basis in the FY 1990 President's Budget.

It is clear that the national budget deficit problems are driving health policy as well as policy in many other major domestic program areas. The efforts to reduce the federal deficit force reductions in funding necessary to support operating programs at their current levels. Since these reductions are usually arbitrary they are made irrespective of the direct and indirect impact on the ultimate beneficiary. Because of the lack of necessary funds the major issues of health care in the U.S. have been inadequately addressed in the FY 1990 budget proposals presented to Congress. The result is disjointed health policy where decisions are influenced most by the mechanisms that would be most effective in contributing to cost reduction -- shortrun solutions rather than longer term strategies for change.

There is growing consensus that it is essential that the country now address options for a fundamental structural reform in the financing and delivery of health care. There are chronic problems of inadequate access to health care, uncontrollable increases in health care costs, increasing numbers of individuals with inadequate or no health insurance and concerns about care for the medically indigent that are forcing the various states to address these serious health care delivery issues independently of the federal government and each other. This latter development will likely result in a serious uncoordinated patchwork of programs if the federal government does not address strategic direction for the future of health care in the U.S.

There is a growing willingness to discuss these major health policy issues within the administration, the health care industry generally as well as in the states. The current administration, however, seems to be consistent with the prior administration in holding the line on reducing investments in health care with the exception of a token commitment for increased funding to improve services to children and pregnant women. The homeless programs (a large component of whom have serious medical problems) have also received some consideration for additional funding.

The states generally seem to be pursuing solutions to the medically indigent problem in the wake of federal government default. They are pursuing varied legislative initiatives designed to make basic health care available to all and/or to provide financial support to hospitals to meet the growing uncompensated care burden. Massachusetts has the most comprehensive statute in place to address the problems of the medically indigent through a mandatory employer based health insurance program. Several states are now planning or considering legislation similar to that which was enacted in Massachusetts in April 1988. The success or failure of these programs will contribute much to the debate about the future of health care in the U.S. Catastrophic coverage under Medicare is a step taken by the federal government in direction of protecting the elderly from the destructive influence of a catastrophic illness.

In spite of these actions the problems of the uninsured and the medically indigent remain to be adequately addressed. The more complex issue of long term care and its funding mechanisms will be debated extensively before reasonable, cost efficient alternatives evolve that are acceptable to the public, the congress and the administration. Unfortunately, each of these major issues is addressed separately, precluding optimal health policy solutions. The absence of a national policy and strategy for implementing the policy coupled with disjointed decision making on major policy issues results in a haphazard, uncoordinated cost inefficient health program for the citizenry.

Major changes in the health care system in the U.S. will continue to occur in the short run, not by design but rather as a result of attempting to control the costs of medical care supported through the federal budget. In this environment those components of the Nation's pluralistic health care system that are functioning well need protection. Similarly, because of severe financial pressure, the Department of Veterans Affairs hospital system demands immediate attention to assure that veterans will continue to receive comprehensive, high quality, cost effective care within the resource base that is made available.

In the following analysis, the components of the FY 1990 federal health budget are reviewed.....and conclusions drawn as to the likely impact of the proposed federal health budget on health care programs that derive all or part of their support from that source.

In our prior analyses of the federal health budget, data from the Department of Defense (DOD) health care programs were not readily available and had been excluded from consideration. The DOD program will amount to approximately $12.6 billion in health care and $250 million

in health research in FY 1989. The DOD program represents more than 8 percent of the total federal health budget of roughly $174 billion for FY 1990. It was not possible to obtain estimates of 1990 outlays from the DOD. Estimates included here were based on recent funding policy and trends.

## COMPONENTS OF FEDERAL HEALTH BUDGET

### MEDICARE

The Administration budget proposes $5 billion in savings in medicare outlays for FY 1990. The savings can be categorized as follows:

- o DRG update factor would be limited to the hospital market basket increase less 2.5 percent.
- o Capital payments would be limited to 18 percent below cost.
- o The indirect medical education payment would be reduced by almost half the current rate.
- o Savings of $1 billion in Part B physician payments.

The continuing annual effort to control costs by reducing the prospective medicare budget requirements by billions of dollars has had a profound effect on the private health care economy. Hospitals continue to close or reduce services in growing numbers (81 hospitals affected in 1988 in 27 states). Many of the hospitals that cannot continue to operate are found in small towns and rural areas and are of 200 bed size or smaller. Such facilities are in locales where alternatives for hospital care may not exist in or near the community.

The principal factor in these closures are the numbers of patients hospitalized, the level of third party reimbursement for episodes of care, length of stay and the ability of the hospital to control or reduce its operating costs. Smaller hospitals have a more difficult time controlling costs because many are built in and cannot be reduced further and, with dropping patient census and fewer patients, the income, which must be spread over fewer patient days, is inadequate under the medicare payment system. Further aggravating this situation are a variety of other factors such as the competition for nuses and their increased costs to hospitals, a problem that is national in scope and beyond the control of hospitals.

The impact of the medicare reductions over the past several years has forced major changes on the health care scene making medical care much less accessible to larger segments of the population. A preliminary analysis by the Prospective Payment Assessment Commission (PROPAC) indicates that more than 50% of all hospitals will lose money treating medicare patients in FY 1989 further aggravating an environment of decreasing amounts of uncompensated care availability.

During the past several years Part B (physicians services) costs have risen dramatically - 15 percent growth in Part B costs last year. Although the shift from inpatient to outpatient care forced by the prospective payment system (DRG's) might seem to be an underlying cause, this is apparently only a minor factor. The 400 percent increase in physician costs between 1976 and 1986 is primarily due to volume growth of 6 percent/year - 9 percent/year recently. The reasons for this volume growth are:

- o the aging of the population which brings about higher utilization because of more frequent episodes of acute illness and more chronic illness.
- o the growth in the number of physicians - making physician care more accessible.
- o increased income of a sizeable portion of the elderly.
- o technological advances - more technology available for use in diagnosis and treatment.
- o shift from inpatient care to outpatient care.

Part B premiums that the elderly must pay will be increased further in FY 1990 and future years if proposals are enacted to move them to a level designed to cover 28% or 29% of costs rather than the 25% of costs covered currently. This is becoming more of a burden to the many who already are experiencing enormous annual out of pocket costs for health care.

### MEDICAID

The inadequate funding of this program continues in the FY 1990 budget proposals. The new administration is proposing to cover children and pregnant women under a medicaid expansion. The program, however, does not address the real problem of the one million people who are denied care each year because they cannot pay for medical care nor does it address the 14 million individuals who need health care but do not seek it because they know they cannot afford it.

In this context it should be noted that:

- o the percentage of individuals who did not visit a doctor in the past year increased from 19% in 1982 to 33% in 1986.

- o 30 percent of low income pregnant women received no health care during their first trimester.

- o 30 percent of black and hispanic hypertensive had not had a blood pressure check within one year.

Most recent estimates indicate that 16 percent of the population of the U.S. is uninsured - or 37 million individuals and the number is growing as more individuals fail to meet the increasingly stringent medicaid criteria for eligibility.

Of the 37 million 75 percent are workers and their families who are not provided medical care insurance by their employers and who are not eligible for medicaid. It is further estimated that one out of five children in the U.S. are not covered by health care insurance.

VETERANS MEDICAL CARE

The FY 1990 budget proposal for the Department of Veterans Affairs (DVA) falls far below the funding level necessary to provide quality health care to eligible needy veterans. Veterans will be denied care in increasing numbers and those veterans who are least able to help themselves will lose access to care that is essential to their well being. The safety net for medically indigent veterans is disappearing and the Department of Veterans Affairs is no longer able to assure that all needy veterans can or will receive medical care. The following summarizes the impact of the FY 1990 funding proposal for the Department of Veterans Affairs medical programs:

MEDICAL CARE

By all accounts, the DVA medical care program has suffered a severe shortfall of funding in FY 1989 that has been documented at about $620 million for health care and an additional deficiency for the medical equipment purchase backlog that approximates $1 billion. This shortfall is not addressed in the FY 1990 budget but at this writing is being addressed as an FY 1989 supplemental appropriation issue. The new Secretary of the Department of Veterans Affairs has requested supplemental support for FY 1989 and additional funding for FY 1990 - but at levels far below that which could be considered adequate. The details of this Department of Veterans Affairs admitted shortfall were extensively documented in hearings held by the House[1] and Senate Veterans Affairs committees on September 7 and 9, 1988 respectively.

The budget proposes reductions in Community Nursing Home Care for veterans. A reduction of 3449 average daily census (ADC) which will result in 11,862 fewer patients treated in FY 1990 than in FY 1989. This is partially offset by a proposed increase in VA Nursing Homes or State Nursing Home program but results in a net decrease of 1575 in ADC and 7983 fewer patients treated. This reduction targets the older World War I and II veterans who currently present the greatest need for nursing home care.

The DVA domiciliary program is proposed to be reduced by 2441 ADC and 6371 patients treated. There is no offsetting proposal for the accommodation of these veterans who usually have difficulty resocializing, are suffering medical and psychiatric problems and may have no home to go to and inadequate income. This is grossly inconsistent with the Administration's professed desire to address the medically indigent homeless problem.

The DVA workload for hospital inpatients treated will be reduced below the FY 1988 level in spite of evidence which indicates that numbers of patients needing treatment will increase substantially as a result of the aging of the veteran population. Although it might be reasonable to expect some of this decrease to shift to outpatient care, the projected workload for FY 1990 outpatient visits has been established at a level below that for FY 1988 thus limiting the opportunity for such shifts to occur. This limiting of access to health care for veterans is proposed in defiance of an increasing demand for health care on the part of veterans.

- o As in previous years, the Administration is proposing a 1% productivity improvement that imposes a reduction of approximately 2000 health care personnel.

- o Although PROPAC has predicted that there will be a 5% cost of living adjustment in FY 1990 -- this is not anticipated in the budget and will result in a shortfall of over $200 million in FY 1990 which will likely have be absorbed causing further reductions in personnel.

- o Employees automatic within grade increases were not included in the budget - an amount that is estimated to be in excess of $50 million which must be absorbed by the medical care personnel account.

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[1]Hearing before the subcommittee on Hospitals and Health Care of the Committee on Veterans' Affairs. House of Representatives, 100th Congress, second session, September 7, 1988, Serial No. 100-58.

o No provision has been made for predictable increases in other employee benefits for FY 1990 (e.g. health benefits).

o Decentralized Hospital Computer Program initiatives in mental health are required to be offset by decreases of $27 million and 659 employees - in advance of demonstrated savings.

o There is recognition of the role of the VA in the treatment of AIDS patients where increases in the funds and personnel for AIDS clinical programs are $55 million and 625 employees.

o Education and training activities which are a part of the major mission of the VA are being curtailed - reductions are proposed as follows: - 175 medical residents; -25 dental residents; -60 Psychology residents; -37 Administrative trainers; and -67 Instructional support personnel. There will be no increases in the funding of or opportunities for continuing education of VA staff.

o There is a legislative proposal for copayments for medical care for category B and C patients as follows:

- veterans will be required to pay $5 (B) and $10 (C) for out-patient visits;

- veterans will be required to pay $3 (B) and $5 (C) for prescriptions;

- veterans will be required to pay $9 per day for hospital in-patient care (both B and C).

- in addition, Category C inpatients are required to make the same copayments as medicare beneficiaries.

MEDICAL AND PROSTHETIC RESEARCH

o The budget reduces the appropriation request for medical and prosthetic research $13 million below FY 1989 and reduces employment by 616.

o The $13 million reduction is proposed for investigator initiated research - the backbone of research in the VA. This will result in a reduction in new proposals that can be funded as well as a cut back in commitments already made to investigators who have on-going projects.

o Health Services Research, which would help the VA improve and become more efficient in service delivery, is not to be increased in FY 1990. Because of past absorptions this is, in reality, a reduction.

o Rehabilitation Research - crucial to the care of veterans and their unique problems remains constant in FY 1990. In reality, this is a reduction because the costs for operating the program will have increased.

o Since no cost of living adjustment is anticipated for FY 1990 the likelihood is that any such increase would also have to be absorbed, further reducing medical and prosthetic research capability.

MEDICAL ADMINISTRATION

o A further reduction of six employees will further inhibit the management capability of the Department of Medicine and Surgery.

TABLE 1
Comparison of President's Budget and Independent Budget for Veterans Medical Programs

| Medical Programs | A Presidents Budget FY 1990 (000's) | B Independent Budget FY 1990 (000's) | B-A Difference (000's) |
|---|---|---|---|
| Medical Care | $10,741,431 | $12,440,400 | $1,698,969 |
| Research | 197,310 | 249,200 | 51,890 |
| Medical Administration | 48,541 | 53,940 | 5,399 |
| State Homes | 42,000 | 42,000 | 0 |
| Grant to Philippines | 500 | 500 | 0 |
| Total | $11,029,782 | $12,786,040 | $1,756,258 |

o Since an employee cost of living adjustment is not anticipated in the budget further reductions in personnel can be anticipated at a time when the medical care program is being severely stressed.

o Health Professions Scholarships will increase by $653 thousand. These programs will support 310 nursing, 40 physical therapists and 30 pharmacy students.

THE INDEPENDENT BUDGET

The Independent Budget[2] bears little resemblance to the administration's FY 1990 budget. The Veterans Service Organizations (VSOs) developed their budget estimates based on the need of veterans for health care using DVA data sources as well as other sources of information to project the health care requirements of veterans. The VSOs submit that their budget estimates are much closer to the true requirements to maintain services to veterans through the VA health care system. Following is a comparison of the FY 1990 President's Budget and the Independent Budget recommendations (see Table 1).

TABLE 2
Federal Health Care Budget by Function
(Outlays in millions of dollars)

| Category of Health Care Budget | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 Proposals | Percent Change 1989-1990 | Percent Change 1985-1990 | Avg.Annual Percent Change |
|---|---|---|---|---|---|---|---|---|---|
| Medicare | 65,822 | 70,164 | 75,120 | 78,878 | 86,778 | 94,918 | 9.4% | 44.2% | 8.84% |
| Medicaid | 22,655 | 24,995 | 27,435 | 30,462 | 34,301 | 37,616* | 9.7% | 66.0% | 13.21% |
| Other Health Care Serv | 4,329 | 3,855 | 5,181 | 5,557 | 6,257 | 6,396 | 2.2% | 47.7% | 9.55% |
| Education and training | 468 | 529 | 556 | 541 | 536 | 459 | -14.4% | -1.9% | -0.38% |
| Research+ | 5,433 | 5,894 | 6,138 | 7,173 | 7,887 | 8,594 | 9.0% | 58.2% | 11.64% |
| (VA) | (215) | (181) | (195) | (197) | (206) | (199) | -3.4% | -7.4% | -1.49% |
| (DOD) | (310)* | (320) | (344) | (331) | (349) | (350)** | | | |
| Consumer and Occupational Health and Safety | 1,182 | 1,165 | 1,197 | 1,285 | 1,345 | 1,316 | -2.2% | 11.3% | 2.27% |
| Veterans and Medical Care | 9,547 | 9,872 | 10,266 | 10,755 | 11,155 | 11,313 | 1.4% | 18.5% | 3.70% |
| Department of Defense Health | 8,950 | 10,080 | 11,152 | 12,053 | 12,619 | 13,212** | 4.7% | 47.6% | 9.52% |
| TOTAL | 118,386 | 126,554 | 137,045 | 146,704 | 160,878 | 173,824 | 8.0% | 46.8% | 9.37% |

+Details for DOD and VA included in this line is shown in parentheses.
*Bush proposal for Medicaid coverage for pregnant women and children included.
**Estimate

[2]The Need is Now, An Independent Budget by Veterans for Veterans' Programs. FY 1990. Published by AMVETS, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars - January 1989.

## THE FEDERAL HEALTH CARE BUDGET - ANALYSIS BY MAJOR PROGRAM FUNCTION.

There was an overall increase of 8.0 percent in the President's health care budget over FY 1989 which includes additions to medicaid in the preliminary budget modifications recommended by the new administration. There are three categories in which increases were above the overall average increase - medicare 9.4 percent, medicaid 9.7 percent and research 9.0 percent. All other categories experienced only slight growth or decreases from the funding levels in 1989 which clearly implies that these programs are not adjusted for medical care inflation (see Table 2). With the medical CPI estimated at 7.2 percent for FY 1989 and forecasted to be a similar percentage for FY 1990, it is clear that the operations level will decrease in each functional area. The categories with the largest increases are the focus major public policy discussions and reflect a desire to keep the lid on the underlying concerns. The country is experiencing increasing numbers of older Americans, using considerably more health care - especially physician services which is driving up medicare outlays. Coupled with growing discontent with the funding mechanisms in place for catastrophic coverage and growing numbers of medically indigent and uninsured people the administration and the Congress are faced with difficult decisions.

TABLE 3
Elderly Out-of-Pocket Health Care Costs

| Year | Elderly Out-of-Pocket Health Care Costs | Percentage of Elderly Income |
|---|---|---|
| 1988 | $2,394 | 18.1% |
| 1987 | 2,145 | 17.4% |
| 1980 | 966 | 12.7% |
| 1977 | 712 | 12.3% |
| 1966 | 300 | 15.0% |

The plight of the elderly brings the issue of inadequate funding more clearly into focus by looking at trends in out-of-pocket spending for health care. Out-of-pocket spending is rising at a much faster rate than is the median income of those 65 years of age and older. From 1987 and 1988 the out-of-pocket spending by the elderly was as a percentage of income was 17.4% and 18.1% respectively. This is an

TABLE 4
Percent Distribution by Function
Fiscal Year 1985 - 1990

| Category of Health Care Budget | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 Proposal |
|---|---|---|---|---|---|---|
| Medicare | 55.60% | 55.44% | 54.81% | 53.77% | 53.94% | 54.61% |
| Medicaid | 19.14% | 19.75% | 20.02% | 20.76% | 21.32% | 21.64% |
| Other Health Care Serv | 3.66% | 3.05% | 3.78% | 3.79% | 3.89% | 3.68% |
| Education and training | 0.40% | 0.42% | 0.41% | 0.37% | 0.33% | 0.26% |
| Research | 4.59% | 4.66% | 4.48% | 4.89% | 4.90% | 4.94% |
| Consumer and Occupational Health and Safety | 1.00% | 0.92% | 0.87% | 0.88% | 0.84% | 0.76% |
| Veterans Medical Care | 8.06% | 7.80% | 7.49% | 7.33% | 6.93% | 6.51% |
| DOD | 7.56% | 7.96% | 8.14% | 8.22% | 7.84% | 7.60% |
| TOTAL | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% |

increase from 15% when medicare and medicaid began. This original level dropped to approximately 12% in the period 1977 to 1980.

The spending category that has grown most rapidly is the medicare Part A deductible and coinsurance payments, rising from an average of $56 per medicare beneficiary in 1980 to $560 per beneficiary in 1989. Part A of the medicare program covers inpatient hospital and skilled nursing facility care; the deductible is set at a level that approximates the cost of the first day of a hospital stay. The average expenditure per inpatient hospital day has risen much faster than has spending in other areas of the economy.

Many factors contribute to this inflationary trend, but one key element relates to the declining length of hospital stays brought about by the prospective payment system.. Many hospital costs are fixed, and these costs are spread across fewer patient days when the average length of stay drops. Consequently, the medicare prospective payment system has contributed to reducing the number of days medicare beneficiaries spend in the hospital during each admission, but it has also contributed to increased out-of-pocket spending associated with the Part A deductible.

It was estimated that in calendar year 1988, those 65 and over averaged nearly $2,400 per year in out-of-pocket spending. P.L. 100-360 The Medicare Catastrophic/Care Act of 1988, will not reduce average per capita health care spending, although some low income veterans may benefit from a slight reduction in combined premium and acute care health costs. Nursing home care costs are expected to continue to increase. Many veterans entitled to medical care through VA facilities may well give serious consideration to the VA medical system as an alternative source of medical care. Most of those who qualify will be able to use a comprehensive array of services available free of charge, including services not covered by medicare (such as long-term nursing home care) or covered by medicare only after payment of annual deductible. Moreover, use of VA facilities will allow many veterans (Category A and B) to avoid payment of medicare Part B premiums and/or avoid spending down to medicaid levels in order to receive nursing home care.

Medicaid, which has been underfunded for years has given rise to increasing numbers of medically indigent who are unable to meet the increasingly stringent criteria for participating in the program. Children and pregnant women are now to receive some consideration under proposals by the new administration but the inadequacies of the medicaid program are forcing the states to implement a variety of uncoordinated programs to address the medically indigent problem. This will result in a patchwork that eventually will require federal intervention and coordination.

The AIDS epidemic has also imposed heavy burdens on the health care system by increasing the burden of uncompensated care and increasing costs to the medicaid program continues to grow to unpredictable levels. A solution to the AIDS problem is an imperative and is recognized in the growing federal investment in research.

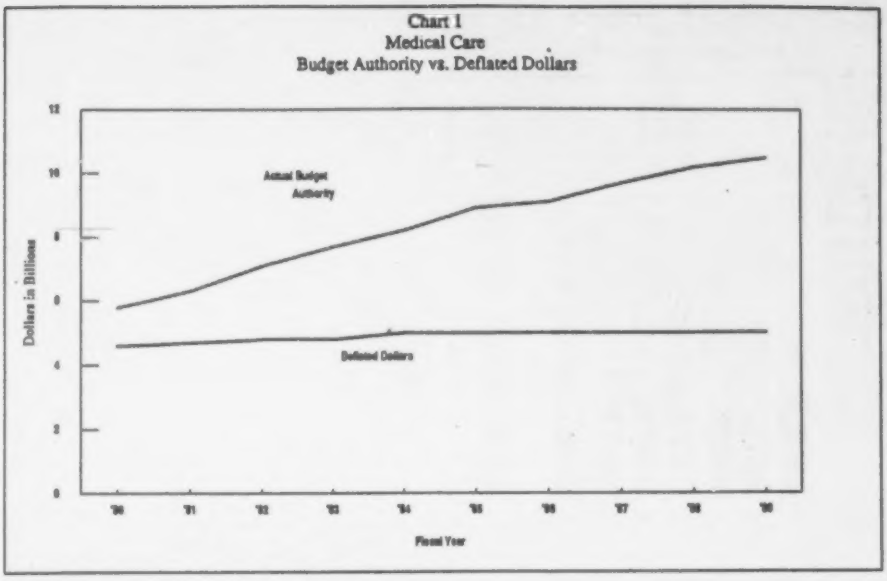
Medicare and medicaid combined, continue to consume increasing proportions of the federal health dollar and, since these programs are placing the greatest strains on the health care budget, all other health functions are experiencing a decline in their share of the budget available and actual dollar reductions in some instances. Even though other components of the federal health sector are experiencing declines or stabilization, proposals for funding do not allow adequate increases for medicare and medicaid. An exception occurs in the research component where Department Health and Human Services has received increased funding for AIDS related research programs.

It is distressing to follow the funding experience of the veterans medical care program which has experienced a constant uninterrupted decline in the share of the federal health care budget since 1985 a trend that began in the late 1970's . This program, an integral part of the health care system designed to meet a commitment made by the federal government to veterans, continues to be squeezed to the point where health care access for needy veterans is increasingly difficult and quality of service is seriously eroding.

Using data from a recent DVA analysis it is possible gain perspective on the efforts of funding policy on the medical care programs. From Charts 1-4 it is apparent that the DVA has become considerably more cost efficient over the time period and that although the nominal dollars available for care have grown, deflated dollars have remained relatively constant. Workload continues to increase is all programs with insufficient funding to meet the calculated requirement to assure access and quality care for needy veterans.

If the DVA medical programs were to receive the same share of the federal health budget in FY 1990 as it received in FY 1985 its proposed budget would be $2.7 billion higher than that proposed by the Administration. If it were to receive the same increase as that proposed for Medicare for FY 1990 (9.4%) the program budget would have been $5.0 billion higher than the President's Budget. It would seem that the obligation of the federal government to veterans is at least equal to, if not higher, than that to the general population.

Chart 1
Medical Care
Budget Authority vs. Deflated Dollars




Clearly, the funding philosophy does not consider the medical need of veterans nor does it reflect an understanding of the roles of the DVA in the larger health care system. This is evidenced in FY 1989 by a demonstrated shortfall in veterans medical care programs alone that approaches $1 billion, a back-log of equipment needs and an irreversible shortfall in the need for construction, repair and maintenance of the DVA medical care system. The accumulated deficits can be indisputably documented. The federal health budget is being artificially constrained and the inadequate funding for federal health programs in general is apparent from cursory study of tables 2 and 4. Chart 1 depicts clearly the effect of budget policy on DVA medical care which indicates a level budget in deflated dollars for the past several years.

## CONCLUSIONS

It was clear in FY 1989 that the inadequate fiscal support policy as reflected in the President's Budget was having a severe negative impact on the VA medical care delivery system that was characterized as follows:

1. A continuing growing aging veteran population requiring increasing amounts of health care;

2. Continuing increases in inpatient workload (Chart 4);

3. Large increments in outpatient workload (Chart 3);

4. Increasing long-term care workload (the DVA being the only long-term care refuge for veterans, especially those over 65), since Medicare does not provide such coverage and Medicaid serves only a third of those who have exhausted their financial resources (Chart 2);

5. Increasing evidence of denial of care to veterans who need outpatient care but are being screened out, legitimately, utilizing more subjective interpretations of existing law;

6. Increasing evidence of rationing of high-cost inpatient care;

7. Queues for elective surgery and for long-term care beds, especially nursing home care;

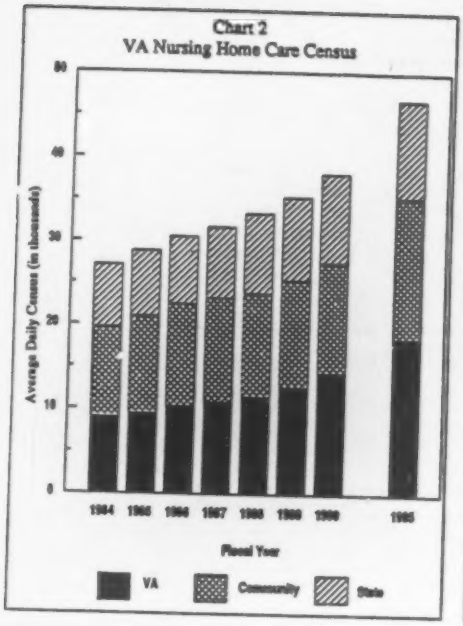


Chart 2
VA Nursing Home Care Census
Average Daily Census (in thousands)
Fiscal Year
VA
Community
State

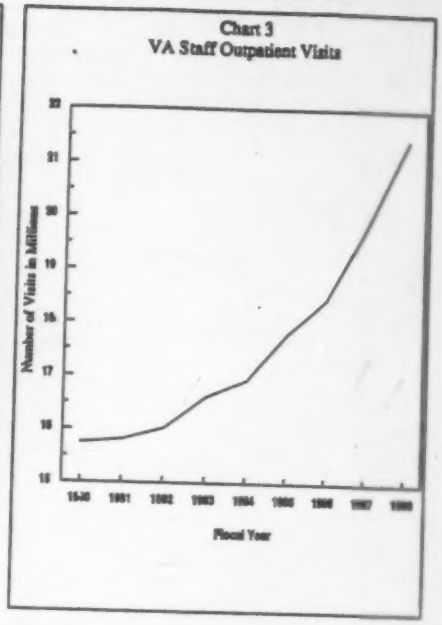


Chart 3
VA Staff Outpatient Visits
Number of Visits in Millions
Fiscal Year

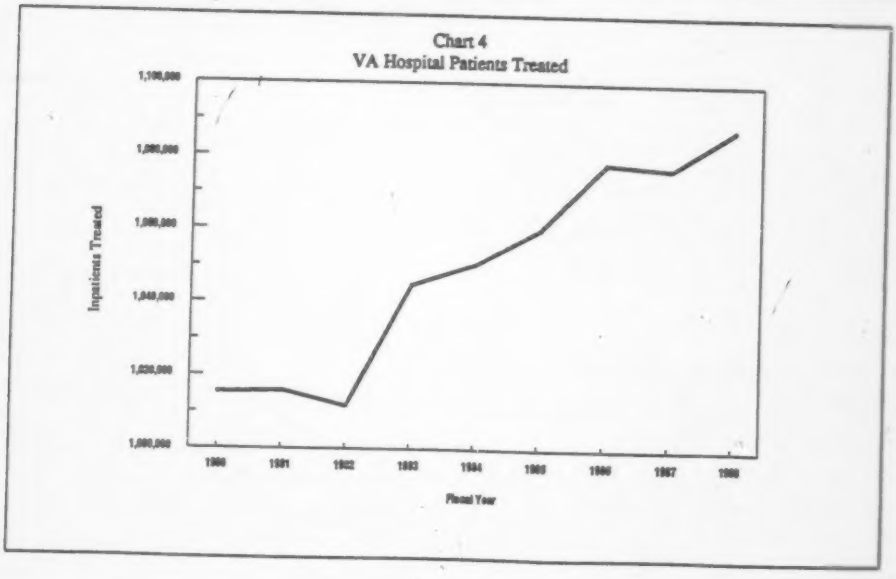


Chart 4
VA Hospital Patients Treated
Inpatients Treated
Fiscal Year

8. Unfunded medical equipment needs that approach the one billion dollar level (see 12 below);

9. Outmoded technology and physical plant;

10. The growing AIDS epidemic imposing new burdens of caring from 7 percent of the AIDS victims in the U.S.; and

11. Deteriorating staff morale.

12. Increasing use of nonrecurring funds to meet recurring obligations. This will have a devastating long-run impact on the VA health care system since recurring obligations will accrue without a budget base to support them. There is clear evidence that in FY 1988 numerous medical centers used all of their equipment funds and maintenance and repair funds to pay salaries that were inadequately funded. It is not possible for the VA health care system to be required to maintain a personnel ceiling of 194,720 and not be provided funding to support that employment ceiling and the special pay rates that must be established for the Veterans Administration to remain competitive--especially in the area of nursing care.

These are among the most obvious effects of the inadequate budget that have been identified through our independent survey efforts have now been substantiated by hearings held by the House and Senate Veterans Affairs Committees. There is now evidence in FY 1989 of curtailment of care in the VA system with medical centers closing clinics to new appointments and some medical centers closing inpatient care to Category B and C veterans.

The budget inadequacies will force major structural changes in the location and availability of veterans health care in the short run. The unfortunate consequence is the forcing of change in this large component of the health care system in the absence of a long run strategy for the entire health care system. Such indirect action threatens the viability of the veterans health care system in terms of its ability to meet its primary obligation to eligible veterans while the gaps created in the system by such action are not adequately addressed. This is taking places in an environment where the role of the DVA medical care system is not understood with respect to how its programs fit into the larger health care system.

To demonstrate this latter point consider four general program areas that have been given explicit recognition by the new administration: AIDS, research, substance abuse and the homeless. The Veterans Health Services and Research Administration (VHS&RA) has large programs and years of experience in each of these four areas, yet it has not been funded as necessary to meet these high priority program areas. A brief review of these four VHS&RA programs is instructive:

AIDS

The DVA has provided care to over 6% of all AIDS patients in the U.S. Since beginning of the AIDS epidemic, over 5800 veterans have been treated, 2161 in 1988 alone. It is expected that approximately 2800 new patients with AIDS will be seen in 1989 and 3600 in 1990, in addition to two to three times as many patients with ARC and HIV infection. Medical centers in the epicenters of the disease (east, west and gulf coasts) are the hardest hit. However, all medical centers will need resources to implement universal blood and body fluid precautions as a result of the epidemic.

Based on data from the VHS&RA the FY 1989 cost of AIDS program was $131 million - $23 million was appropriated and $108 million had to be taken from other items in the health care budget to cover the costs. The increasing epidemic will cost $165 million in FY 1990 and the amount that will have to be absorbed with current funding proposals is $80 million.

RESEARCH

AIDS research, would be increased if additional resources became available. Medical research has developed a critical mass of investigators in AIDS-related research via the Special Solicitation for AIDS projects and the request for establishment of AIDS centers. In addition, Health Services Research and Development will initiate a multi-medical center project on the delivery of health care to AIDS patients costing approximately $400,000 in 1990. The investigators at the AIDS centers will be initiating approximately 15 new research projects in 1990 and would increase those new starts to approximately 25 with additional funding of $900,000.

As mentioned above the FY 1990 budget for research in VHS&RA has been decreased by $13 million thus compromising the ability and capacity to carry out a role for which it has a unique capacity and opportunity. In FY 1990 $7.5 million will be spent on AIDS research by DVA. Six percent of the $1.6 billion appropriated to the secretary of Health and Human Services for the research and prevention of AIDS would amount to $112 million if VHS&RA were to be considered in a reallocation of such funds in FY 1990.

SUBSTANCE ABUSE PROGRAMS

As of the end of 1988, approximately 150 of the VA's 172 medical centers and outpatient clinics had drug, alcohol or

combined substance abuse treatment programs in operation. Modalities involved include inpatient treatment, outpatient care, methadone maintenance in 35 settings, and the contract halfway house program under which approximately 90 VA medical centers contract with approximately 400 community halfway houses for ongoing residential treatment of alcohol and other substance abusers. Of particular relevance in understanding VA programming in drug and alcohol abuse is the fact that the typical patient being treated within the VA in this sector is a multiple substance abuser. Drugs of abuse usually include alcohol, and one or more other drugs, with cocaine and marijuana being the primary associated drugs of abuse. As a result of this phenomenon, most VA treatment programs, whether they are identified as drug or alcohol programs, actually treat combined substance abusers. Indeed, many programs have begun to define themselves as substance abuse programs rather than as alcohol treatment or drug treatment. Thus, fiscal differentiation of alcohol and drug abuse treatment programs is becoming less relevant in view of clinical reality.

The budget estimate for alcohol and drug abuse treatment is $340,481,000 in 1989 and $349,913,000 in 1990. The 1989 figure does not include the $1 million authorized by section 2501 of PL 100-690 which provides for conducting an evaluation of drug and alcohol programs in 1989. To date, no authorized amounts included in this public law have been appropriated for the DVA.

HOMELESS PROGRAMS

The VHS&RA has developed a comprehensive network of health care services for our Nation's veterans. Many of these services and programs, although not specifically designed for the homeless, have assisted homeless veterans. In addition to the array of general VA services, two programs are authorized through legislation with specific mandates to provide health care services to homeless veterans: the pilot Homeless Chronically Mentally Ill (HCMI) program and the Domiciliary Care for Homeless Veterans (DCHV) program. The 1990 request includes $13,872,000 for HCMI and $10,852,000 for the DCHV program.

The HCMI program, was initially activated under the authority of P.L. 100-6. The authorization for this program was recently extended by P.L. 100-322. Through these public laws, the DVA is authorized to contract with community-based psychiatric residential treatment programs to provide treatment and rehabilitation for homeless veterans that suffer from chronic mental illness. The DCHV program was established as a specialized treatment component within the DVA Domiciliary care program. Authorized by P.L. 100-71, the DCHV program provides rehabilitation and treatment to veterans in need of clinical services who are homeless or whose living situation is so tenuous that they are at serious risk for homelessness. The focus of the program is to provide treatment that will prepare the veterans to return to independent living. The FY 1990 budget is proposing a reduction of 2440 in domiciliary census and 6370 patients treated at a time when such programs have been given priority.

Total funding levels for these two programs are $23,619,000 in 1989 and $24,724,000 in 1990. No appropriation has been provided and program costs have been absorbed. The resource levels will support 43 HCMI programs and an estimated 446 additional domiciliary average census. The authorized funding level provided in the McKinney Act Amendments of 1988 is $30 million, $15 million for each program.

With funding, additional therapeutic components would be established within the HCMI programs and the DCHV programs would activate new sites and expand existing programs. Based on proposed legislation recently introduced by the Congress, HCMI program officials could link Compensated Work Therapy Programs with Therapeutic Residences for up to 15 new components which would allow VHS&RA to care for approximately 150-200 additional veterans. The average daily census in the DCHV program would increase by approximately 210 if the program was funded at the level authorized in the McKinney Act. It should be noted that approximately one third of the homeless are veterans - but one third of the funds to be allocated to the homeless programs are not available for the Department of Veterans Affairs.

It is not unreasonable to suggest that portions of federal funds appropriated these national priorities be made available to the Department of Veterans Affairs to address the veteran components of the problem areas. This would place badly needed resources in ongoing programs to address these pressing problems in the veteran population. The federal budget would not be increased overall if such a reallocation could be achieved.

It is timely to consider the entire health care system in terms of meeting the challenge of increasing costs and increasing needs of the growing elderly population. All of the quick fixes are but temporary solutions to a complex medical care problem. And, in the case of programs of the Department of Veterans Affairs results in denial of needed care to those who have been given a government promise to care for him who has borne the battle.....

*Statement of*

# *The American Legion*

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

SAMUEL J. WALSH, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

RICHARD S. CHRISTIAN, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

on

## OUTPATIENT CARE AND OTHER VETERANS HEALTH CARE ISSUES

April 26, 1989

STATEMENT OF RICHARD S. CHRISTIAN, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
APRIL 26, 1989

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to present its views on H.R. 1780, as well as several other issues scheduled for consideration today, all of which relate to the Department of Veterans Affairs medical care system.

Mr. Chairman, we are greatly disturbed by the fact that Category B and C veterans, as well as some Category A nonservice-connected veterans are not being provided essential and basic health care services in the name of cost savings.

Recently as you know Mr. Chairman, The American Legion conducted a survey of all VA medical center directors to determine the degree of FY 1989 budgetary shortfalls on each facility, and to assess what impact the reported funding shortages are having on the provision of medical care to veterans. Our findings have shown that 148 of 159 facilities surveyed are operating with significant decremental budgets this fiscal year. The reported shortages are having wide-ranging effects on the delivery of health care services, with cutbacks and reductions in services reported across a broad spectrum of medical center activities.

According to our survey results, the greatest degradation in health care services is being borne by the nondiscretionary veteran workload, specifically the Category B and C veterans.

Mr. Chairman, The American Legion was opposed to the implementation of the means test from its inception and we will continue to oppose it. The administration of the means test has placed a burden on medical center staff and, to our knowledge, it has never proven cost-effective.

With respect to H.R. 1780, The American Legion supports the intent of this proposal to expand, to some degree, outpatient care by making the eligibility criteria consistent with inpatient care. However, upon review, the language is unclear in this respect, when applying the provisions of section 610, title 38, USC, to treat all veterans.

The budgetary constraints and resource allocation methodology on the provision of VA care in rural areas is more critical than in urban medical centers which maintain extensive affiliation programs with university medical schools.

For reasons previously enumerated the ability of the discretionary workload to successfully be referred to community health services is affected by the degree of available community services. Rural areas generally have a less extensive network of community health care resources. Also, rural VA medical centers which are nonaffiliated or have only a small affiliation program are reimbursed less under current resource allocation methodologies than large affiliated VA medical centers, for the same workload produced. For the two reasons mentioned, geographic location and the degree to which a VA medical center is affiliated with a university medical school, we believe the provision of VA health care in rural areas is less accessible to the nondiscretionary workload, and thus, the chances of veterans being successfully referred to local community services in rural areas is considerably less than in urban locations.

In our estimation it is therefore extremely important for the VA to maintain the vitality of rural medical centers and outpatient clinics so that accessibility to care is similar to that which veterans have in larger urban areas.

In comparing the costs of providing VA and non-VA health care it is difficult to find fully reliable information to use as a guide. We are aware of only one VA initiated study on this subject area which has been completed. This study, completed in May 1986, focused on comparative costs of inpatient hospital care between the VA and the private sector. The main conclusion of the study was that the cost of acute care in VA medical centers is consistent with, and comparable to, the estimated cost of acute care in non-VA facilities for the same mix of patients. An important difference noted, however, was in add on charges, in addition to health care costs, which are typical in non-VA health care facilities.

The study was initiated in mid-1985 and was based on 1984 data. We understand another VA initiated study to compare VA and non-VA health care costs is currently underway and the results will not be available for another few years.

Mr. Chairman, the next item we shall comment on involves draft legislation which would amend section 612 of title 38, United States Code, to authorize the Secretary of Veterans Affairs to provide certain procreative services, and reimbursement of certain adoption expenses, for married veterans with service-connected disabilities.

There are a relatively limited number of veterans who would be eligible for these services and an even smaller number who would avail themselves of them.

Obviously, the vast majority of those individuals who would receive this assistance are Vietnam veterans who, without the application of special procedures to overcome the service-connected impairment of their procreative ability, would not be able to parent natural children. In consideration of these circumstances, we would not oppose the intent of this section.

Mr. Chairman, that completes our statement.

United States General Accounting Office

GAO Testimony

For Release
on Delivery
Expected at
9:00 a.m. EDT
Wednesday
April 26, 1989

# VA's Health Care Planning Process

Statement of
David P. Baine
Director of Federal Health Care
Delivery Issues
Human Resources Division

Before the
Subcommittee on Hospitals and Health
Care
Committee on Veterans' Affairs
House of Representatives

GAO/T-HRD-89-18

GAO Form 160 (12/87)

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the planning process that the Department of Veterans Affairs (VA) uses in its health care delivery system. As you know, VA's system includes 172 medical centers located in 27 medical districts. In fiscal year 1981, VA adopted a new planning process, referred to as Medical District Initiated Program Planning. This process established the 27 medical districts as the focal points for assessing veterans' future health care needs and developing strategies for meeting these needs.

In 1985, VA required each district to review its medical centers' performances and seek opportunities for increasing the cost-effectiveness of services, consolidating services, or eliminating less essential services so that resources could be used for higher priority services. At this Committee's request, we examined the process that VA used in deciding to make service delivery changes at its medical center in Prescott, Arizona. Officials in VA's medical district 24 recommended that inpatient surgery be discontinued at the Prescott center and that the center's capability to provide outpatient and extended care services be enhanced. In keeping with VA's decision-making process for such changes, the recommendation was reviewed by the regional planning board and headquarters officials, including the chief medical director. In June 1986, the then Administrator of

Veterans Affairs approved the recommendations which were later implemented.

Our review of the Prescott decision provides valuable insights regarding VA's planning process as a whole and the difficult decisions that must be considered when major changes are made in medical centers' service delivery capabilities.. In doing our work, we interviewed knowledgeable officials at each level of the review process. We also examined VA's planning guidance and procedures and evaluated the information that formed the basis of the recommendations made by officials at each level.

Let me say at the outset, Mr. Chairman, that in an era of federal budget constraints, VA must make difficult decisions about how best to organize and allocate its resources to serve the nation's veterans. These decisions necessarily involve striking appropriate balances among competing demands of veterans in each medical center's service delivery area. For example, in the case of the Prescott center, VA had to balance the competing demands of veterans needing inpatient surgery with the growing needs for general medical care of an aging veteran population. Our work shows that in its decision about the Prescott center, VA appropriately (1) considered the essential factors needed to make a decision, (2) used the best data available, (3) involved both clinicians and administrators in field and headquarters positions, and (4) made the decision in the context of the

service delivery capabilities of other centers in Prescott's surrounding area.

FACTORS CONSIDERED IN VA'S ASSESSMENTS

VA considers many factors in assessing the mix of services each center should deliver. Among these are the projected needs of the veteran population, veterans' access to needed services, and the cost-effectiveness of the services provided.

In evaluating the Prescott center, VA used utilization and demographic data to project veterans' needs for surgery, extended care, and outpatient services through the year 2005. Secondly, it assessed whether access to these services would be available at other facilities in the surrounding area if changes were made at the Prescott center. VA considered waiting times for appointments at receiving medical centers and travel considerations including the cost and difficulty of travel. Finally, VA compared the volume and complexity of surgical procedures performed at the center with its cost of doing those procedures. It then compared this information with similar information for the district.

After evaluating these factors, VA decided that the Prescott center should emphasize enhanced extended care and outpatient services and should discontinue its inpatient surgical

service. VA concluded that all three types of services were needed by veterans in Prescott's service area. It also concluded that the need for the former two types of services outweighed that for inpatient surgery, which was determined to be accessible at other facilities and more cost-effective to provide. Further, VA decided that it could meet veterans' needs for some surgery by maintaining an outpatient surgical capability at the Prescott center.

## DATA USED IN VA'S ASSESSMENT

It is essential that VA's health care planning decisions be based on data that are comprehensive, reliable, and current at each level of the review process. We believe that in the decision regarding the Prescott center the data VA used were the appropriate data to review, the most reliable data available, and current at each level of the review process.

## OFFICIALS INVOLVED IN THE PLANNING PROCESS

Determining the appropriate mix of services at a medical center involves making decisions about both clinical and administrative matters. It is important, therefore, that the perspectives of both clinicians and administrators be considered at all levels of the review process. In the case of the Prescott center, VA did this. Medical center staff participated in the

development of plans to change the center's service capability. Five of the seven members of the district planning board that recommended service delivery changes were physicians. The regional planning board that reviewed the decision had five physicians and one nurse among its nine members. One-half of the members of the two headquarters review boards that considered the decision were physicians. Finally, a surgical task force, appointed following the deputy administrator's November 1987 request for a reevaluation of the decision, was composed of three members, two of whom were chiefs of surgery from medical centers outside the district.

## SERVICE DELIVERY ASSESSMENTS REQUIRE BROAD CONTEXT

As we indicated earlier, VA must consider many competing demands when making decisions to change a medical center's service delivery capability, especially during this time of tightening budgetary constraints. Each medical center may not have the resources available to meet all the health care needs of veterans in its service area. Given these constraints, VA's decisions should consider the health care needs of veterans in areas larger than those served by individual medical centers.

Decisions made for services to be provided at the Prescott center reflect such a consideration. VA chose to increase access at Prescott for patients in the medical district requiring

extended care and outpatient services. But VA decreased the most convenient access to inpatient surgical care for some veterans in the Prescott service area because they would have to travel to other medical centers. VA engaged in a thorough review of the competing and projected needs of veterans in northern Arizona and appears to have reached a reasonable decision concerning how to meet those needs effectively.

In conclusion, Mr. Chairman, we would like to reiterate that VA faces tough choices in deciding whether to change the service delivery capabilities of its medical centers. We believe, however, that as veterans' needs for VA services change and, perhaps, increase faster than resources are made available to meet those needs, VA must continue to make these difficult decisions. Accordingly, it will become increasingly important that VA's planning process provide assurance that decisions are both soundly based and directed toward serving veterans' most pressing needs for VA health care. VA's planning process as it led to the decisions concerning the Prescott center appears appropriate for meeting these challenges.

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This completes my prepared statement, Mr. Chairman. My colleagues and I would be pleased to respond to your questions.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUN 12 1989

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans'
Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed please find the Department's responses to questions raised by Representative John Paul Hammerschmidt following the April 26, 1989, hearing on Health Care. A copy of these responses has been provided to Representative Hammerschmidt.

Sincerely yours,

Edward J. Derwinski
Secretary

Enclosure

cc: Honorable John Paul Hammerschmidt

# WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CONGRESSMAN HAMMERSCHMIDT

Question: 1. Of the 172 VA medical centers, how many are located in rural or remote locations?

Answer: We do not classify or categorize either our medical centers or outpatient clinics as "rural" or "urban." VA medical centers are the locus of activity and attention, and a critical base from which VA planning efforts are made. It is the medical center which oversees and supervises care within its primary service area--including care provided in satellite, community based and outreach clinics--whether it be an urban or rural environment. All our studies in the past including three previous reports to Congress, have focused instead on distance or transportation barriers between the population to be served and the servicing VA medical center. For example, in the 1985 study and report to Congress, we concluded that about 97% of the veteran population lived within 100 miles of a VA medical center, and that only a very few pockets of remoteness and rurality presented a difficult challenge of access to VA care. More recently, an internal survey (Summer 1988) found that over 200 outpatient activities were operating in areas physically away from the "parent" VA medical centers. About one-half of these activities could be considered functioning in rural or remote areas. We have not to date conducted a specific rural-urban analysis of the dispersion of these activities, and see no need for such an analysis.

Question: 2. Of the 229 outpatient clinics, how many are located in rural or remote locations?

Answer: See answer to Question 1. above.

Question: 3. Please describe in greater detail the Resource Allocation Methodology as it is applied to small, unaffiliated, rural facilities.

Answer: There is no special application of the Resource Allocation Methodology (RAM) for small, unaffiliated, rural facilities. A previous adjustment to the budgets of small, unaffiliated, rural facilities was eliminated from the RAM in the FY 1988 RAM. That adjustment, when in use, placed a cap, or limitation on the amount of RAM earnings by those facilities. Beginning with the FY 1989 RAM, VA facilities were placed in peer groups of similar facilities and competed with the facilities in their group.

Question: 4. In your testimony, you indicate that the DVA has developed other service delivery mechanisms to improve access to health care services. Your testimony lists Hospital Based Home Care as one of these mechanisms. What is the limitation on the number of miles that a member of the Hospital-Based Home Care Team may travel to care for a veteran?

Answer: Hospital Based Home Care team members travel about a 30 minute/30 mile radius from the medical center. This is the same service radius generally used by community home agencies. In areas distant from the VA Medical Center we have established satellite home care programs which effectively expand the primary service area of the medical center. Satellite home care programs have been established at Hot Springs and Pine Bluff, Arkansas as an extension of Hospital Based Home Care at the Little Rock, Arkansas Medical Center. A professional staff of registered nurses and social workers who live in those areas was recruited to provide the patient care. This program model has been evaluated and found to be an efficient way to improve access to health care services. Planning guidance has been distributed to the field and several medical centers have expressed interest in developing the model.

CONGRESSMAN HAMMERSCHMIDT

Question: 5. Are we predestined to end up with very little rural VA medical care because our allocation formulas favor the most effective, densely populated areas that will have high utilization rates?

Answer: We are not predestined to have very little rural VA medical care because of the Resource Allocation Methodology (RAM). Some of the smaller VA facilities are as efficient and effective as larger VA facilities. In FY 1988, a method was developed to group hospitals into clusters of like facilities based on mission and size-related variables. This peer grouping of VA facilities for the FY 1988 RAM eliminated any competition between small rural facilities and large urban facilities in the FY 1989 RAM.

Question: 6. The two DVA pilot programs at Farmington, New Mexico and Redding, California are described as primary care clinics designed as alternatives for care in rural areas. How do these clinics differ from other DVA outpatient clinics?

Answer: The Redding, California, clinic is essentially a "traditional" VA satellite or community-based clinic, which offers primary care with a relatively low degree of complexity. It also represents a substantial investment in the community. It operates in a rural setting, and is "independent" in the sense it is self-contained, staffed with full-time VA employees, including physicians, nurses and various technicians, and operates within its own "free-standing" management structure, although it is overseen by the Director, VA Medical Center, Martinez, California.

The Farmington, New Mexico, clinic is based on a different premise, and is truly "experimental" in nature. Like Redding, this clinic offers basic primary care with a modest degree of complexity, in a rural area. However, the Farmington facility differs dramatically from Redding in that it is allied with the Presbyterian Medical Services (PMS) clinic and shares space within the PMS community-based clinic facility in Farmington. PMS physicians are on contract to treat VA patients; we purchase a substantial number of other services (laboratory, x-ray, pharmacy, etc.) from PMS; and the VA clinic is supervised and coordinated overall by a physician assistant (a full-time VA employee). The VA staffing level is only about one-third that of the Redding staffing level, but patient visit workloads at these facilities are roughly equal.

Our evaluation is designed to specifically examine these operational differences and their effects on efficiency, quality and cost of--as well as access to--VA medical care in rural areas.

Question: 7. When do you expect evaluations of these projects to be completed?

Answer: Our evaluation is scheduled to be completed in the Summer of 1990, and we will provide the Veterans' Affairs Committees a report of this evaluation. We expect an interim report later this year from our evaluators at the Health Services Research and Development Center, VAMC, Palo Alto, California.

Question: 8. With respect to recruitment and retention problems of DVA health care personnel, have you identified any problems that are specific to rural areas.

Answer: The recruitment and retention problems experienced by DVA are not specific to rural areas. Each medical center has its own unique problems in recruiting and retaining health care personnel. Some facilities in high cost-of-living urban areas such as Boston, New York, San Francisco, have problems because salaries are too low. Some medical centers, located in rural and small city settings, have difficulty attracting health care workers because of the lack of interest in relocating to these areas. Some VA medical centers, both rural and urban, have relatively minor difficulties in maintaining an adequate workforce.

CONGRESSMAN HAMMERSCHMIDT

Question: 9. Dr. Spencer Falcon in his testimony, recommends that efforts should be undertaken to raise the awareness of affiliated hospitals to the special needs of rural hospitals. He specifically recommends establishing shared educational programs, assistance with recruitment of speciality medical professionals, and the formation of closer ties with rural facilities. Are there any plans currently underway to achieve these goals?

Answer: Educational program sharing is already occurring in many VA medical centers. Several of our medical districts have organized education committees which promote sharing of continuing education programs among member VA medical centers. In addition, eight of our remote VA medical centers host Cooperative Health Manpower Education Programs (CHEPs). CHEPs work through consortium arrangements with community educational and health care institutions to develop joint educational activities. We are currently looking at ways to expand the CHEP concept to other VA medical centers.